BEFORE THE
DENTAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation and Petition to Revoke Probation Against: SCOTT WILLIAM SANDARD, D.D.S., Respondent.	Case No. DBC 2006-36 OAH No. L2006120180

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Dental Board of California as its Decision in the above-entitled matter.

This Decision shall become effective January 21, 2008.

IT IS SO ORDERED December 19, 2007.

BOARD OF DENTAL EXAMINERS
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____

rfm

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PROPOSED DECISION

Timothy S. Thomas, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter on September 11 through October 4, 2007, in Tustin, California, and on October 11, 2007, in Los Angeles.

Shawn P. Cook, Deputy Attorney General, Office of the Attorney General, State of California, represented complainant Robert Hedrick, the Executive Officer of the Dental Board of California (hereinafter the board).

Norman L. Schafler, Attorney at Law, represented Scott William Sandarg, D.D.S. (respondent).

During the course of the hearing, complainant moved to amend the Accusation to conform to proof. There were no objections to the first five amendments listed below and the motions were granted. Motion number six was granted over respondent's objection. The amendments are:

1. At page 24, line 10, the word "Acetaminophen" is deleted and the word "Oxazepam" is inserted.

2. At page 13, the date "February 24, 2004" is changed to "September 24, 2004."

3. At page 14, the reference to "80 mg of Valium" is changed to "60 mg of Valium," and the reference to "four tablets of Loratab" is changed to "one tablet of Vicoprofen."

4. At page 28, paragraph 71(d), lines 15 – 16, the address "465 Giotto" is deleted and the address "607 Uttica #3" is added.

5. At page 24, paragraph 63(c), line 11, add the words "and Xanax" after the word "Oxazepam."

6. At page 19, line 19, add "310 milligrams" following the word "Methamphetamine."

The matter was argued and submitted on October 11, 2007. The record remained open, however, through November 2, 2007, to permit respondent to submit documentation to support his assertion that the Orange County Superior Court would, on that date, rule on his petition to expunge the criminal conviction discussed below at Finding 20. The minute order was received by the Administrative Law Judge on November 2, 2007, marked as Exhibit EE, and was received into evidence.

FACTUAL FINDINGS

Original Licensure

1. On November 4, 1997, the Dental Board of California (the board) issued Dental Certificate No. 45006 to respondent.

Prior Discipline of Respondent's Certificate

2. On February 7, 2000, respondent, who was then represented by Phillip E. Solomon, Attorney at Law, signed a Stipulation in Settlement of Accusation (the stipulation) in resolution of Case No. AGS 1999-12 (Accusation AGS 1999-12).

3. For purposes of the stipulation in Accusation AGS 1999-12 only, respondent admitted the factual allegations set forth in paragraphs 1, 2 and 4-8 of the Accusation and that grounds existed to impose discipline against his certificate under Business and Professions Code sections 1680, subdivisions (m) and (s). Respondent stipulated to the entry of a disciplinary order that revoked his certificate, but which stayed the order of revocation, suspended his practice for 30 days and placed him on probation to the board for five years on specific probationary terms and conditions.[1]

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[1] Among other matters, probationary condition 15 provided that if the board requested the Attorney General's Office to prepare an accusation or a petition to revoke probation during the five-year period of probation, then probation would be extended and would not expire until the accusation or petition was resolved; probationary condition 2 required respondent to comply with and complete the board's diversion program; probationary condition 3 required respondent to obey all laws; probationary condition 4 required respondent to submit quarterly declarations to the board advising whether he had complied with probation; probationary condition 7 required that respondent notify the board of his current address of record; probationary condition 12 required that respondent abstain from all use and possession of controlled substances unless legally prescribed for medically or dentally diagnosed health reasons for a bona fide illness or condition.

4. On March 17, 2000, the board adopted the stipulation and the disciplinary order became effective on April 17, 2000. By the terms of the stipulation, respondent's probation was to continue until April 17, 2005.

Jurisdictional Matters

5. On March 28, 2005, board investigator Stephen Nicas delivered to the Office of the Attorney General (AG) a written request that the AG file a disciplinary action against respondent. The delivery effectively triggered condition 15 of the stipulation, thus extending the period of probation until resolution of the instant action.[2]

6. On October 27, 2006, complainant, in his official capacity as the board's Executive Officer, signed the Accusation and Petition to Revoke Probation in Case No. DBC 2006-36 (the current action), which was served on respondent together with all other required jurisdictional documents.

7. The current action alleges that respondent's certificate is subject to discipline for unprofessional conduct as a result of respondent's conviction of a substantially related crime (first cause for discipline), his conviction of a crime involving a controlled substance or dangerous drug (second cause for discipline), for repeated acts of negligence related to his care and treatment of 17 patients from 2002 through 2004 (third cause for discipline), for excessive prescribing (fourth cause for discipline), for the unlawful possession of controlled substances or dangerous drugs (fifth cause for discipline), for obtaining controlled substances by fraud or misrepresentation (sixth cause of action), for the self-administration of controlled substances (seventh cause for discipline), for the use controlled substances in a dangerous or injurious manner to himself (eighth cause for discipline), for failing to follow laws related to the prescribing, dispensing, and administration of controlled substances (ninth cause for discipline), and for aiding and abetting unlicensed persons to perform the duties of a registered dental assistant (tenth cause for discipline). The current action also alleges that respondent's probation should be revoked and the revocation of his certificate that was stayed in the previous case should be reinstated because he failed to complete the diversion program,[3] failed to obey all laws, failed to notify the board of his arrest and his unlawful use

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[2] At hearing, respondent challenged the genuineness of the document (Exhibit 87) that board investigator Stephen Nicas testified he created on March 25, 2005, and hand-delivered to the AG on March 28, 2005. In argument, counsel for respondent suggested that Mr. Nicas had created the document after the fact and that the AG's office may have been complicit in the presentation of false evidence. The suggestion was factually unsupported. The genuineness of the letter was corroborated by an entry in the time log of the initial Deputy AG assigned to evaluate Mr. Nicas' request. The log (Exhibit 70, page 5) established that DAG Timothy L. Newlove spent 2.5 hours in "Case Evaluation/Assessment" on April 12, 2005, five days before the expiration of respondent's probationary period. It may be inferred that Mr. Nicas hand-delivered the letter of referral to the AG because he was aware of the imminent running of respondent's term of probation and his knowledge of condition 15 of the probationary order.

[3] As a result of a stipulation in settlement of a Writ of Administrative Mandamus brought by respondent, the probationary requirement that respondent successfully complete the board's drug diversion program was deleted as a condition of probation. As a result, complainant agreed at trial herein to delete from the current action (at page 27,

of controlled substances, failed to inform the board of his change of address, and failed to abstain from unlawfully using and possessing controlled substances.

8. Respondent's Notice of Defense, dated November 9, 2006, was timely filed with the board.

9. On July 18, 2007, following a telephonic hearing, Administrative Law Judge Stephen E. Hjelt issued a Pre-Hearing Conference Order setting the matter for a 23-day hearing to commence in San Diego on September 11, 2007. Among other matters, ALJ Hjelt left to the hearing judge's discretion the determination of several motions in limine.

10. On August 22, 2007, following respondent's motion for a change of venue and complainant's withdrawal of an objection thereto, Presiding Administrative Law Judge Alan Alvord issued an order transferring venue from San Diego to Tustin.

11. On September 11, 2007, the record in the administrative hearing was opened. Jurisdictional documents were presented. Rulings were made on the motions in limine, as follows: Respondent's motion to preclude evidence not provided in discovery and to limit testimony to any document produced in discovery was reserved, to be determined as individual documents were actually offered into evidence. Respondent's motion to preclude anecdotal evidence and evidence that was not clear or convincing was denied, without prejudice to be renewed upon the offering of individual items of evidence. Complainant's motion to limit the number of character witnesses called on respondent's behalf was denied without prejudice, to be renewed should witnesses actually called offer evidence cumulative on the point.

The 2006 Felony Conviction (The First and Second Causes for Discipline)

12. On February 20, 2004, at approximately 11:00 p.m., Huntington Beach police officers Daniel Boldt and John Topartzer were investigating an unrelated matter in the parking lot of the Carl's Jr. restaurant located at 19512 Beach Blvd., when they noticed respondent, in the same parking lot, applying some sort of liquid to the underside of his vehicle. The liquid appeared to be dripping onto the pavement. Believing the activity was in violation of Penal Code section 374.3, subdivision (a) (the deposit of waste matter on public property), the officers contacted respondent. They asked respondent what he was doing. Respondent told them that he was using a paint stripper to remove the paint from the frame of his vehicle.

13. The officers noticed that respondent "could not stand still," used exaggerated gestures and exhibited rapid and slurred speech. Respondent was sweating heavily, and his pupils were dilated and reacted slowly to light. Respondent told the officers that he was on probation to the board and was subject to search and seizure for drug-related offenses.

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paragraph 71(a), of the Accusation) respondent's alleged failure to complete the diversion program as a ground for discipline or revocation of probation.

Respondent denied that he was under the care of a physician or a dentist or that he was sick or injured. Suspecting that respondent might be under the influence of a central nervous system stimulant, Officer Boldt administered a test that required respondent to sit on a parking block, lean his head back, close his eyes, and estimate when 30 seconds had elapsed. Respondent's eyelids fluttered rapidly, but he estimated the passage of time in 27 seconds. Officer Boldt checked respondent's pulse, which was 152 beats per minute, approximately twice the normal rate. Checks of respondent's pulse over the next hour resulted in findings of 140 and 120 beats per minute. The officer asked respondent if he had used any type of stimulant in the past 12 hours. Respondent said he used Ephedrine before working out.

14. Officer Boldt placed respondent under arrest for being under the influence of a controlled substance. Incident to the arrest, Officer Topartzer searched respondent's truck and found several items of interest to the investigation. First, in a "fanny pack" he found several bottles of pills, including a bottle containing an assortment in excess of 100 pills. Other pills were found in prescription bottles that were labeled "Ibuprofen," "Cyclobenzaprine," "Allegra," and "Diazepam." An empty bottle was labeled "Hydrocodone." Inside of one prescription bottle was found a vial containing a substance labeled "urine luck." Second, Officer Topartzer found a small bindle that contained a white crystalline-like substance. The paper bindle was hidden between two of respondent's business cards that had been taped together and placed in respondent's wallet, which was resting on the floorboard on the driver's side of the vehicle.

Officer Boldt looked in the back of respondent's truck and observed two two-gallon containers of "Klean Strip," and an open bucket containing some of the paint stripper and two brushes.

15. At the jail, after respondent was given the standard *Miranda* warning, he agreed to speak with Officer Boldt. Respondent admitted he consumed "a little bit of methamphetamine" in his coffee at about 6:30 p.m. that evening, and that the powder found between the business cards was indeed methamphetamine. Respondent denied using methamphetamine when working, saying, "I can't do that stuff when I'm working. I go way too fast." When asked what types of pills were in the bottle found in the truck, respondent indicated he could not recall exactly, but believed the pills included Valium, Xanax and herbal Ephedrine. He said a Dr. Comer and a Dr. Vu prescribed the drugs.

16. The powder found in respondent's wallet weighed 0.31 grams (310 milligrams), net, was chemically tested and confirmed to be methamphetamine. The various pills found in the fanny pack were positively identified as set forth in Finding 36.

17. Respondent provided a blood sample within one hour of his arrival at the Orange County jail.[4] The sample was screened for drugs on March 1, 2004, was found

[4] Respondent contends that he offered a urine sample, but did not testify he refused to give a blood sample. Officer Boldt testified he always arranges for a blood sample because he thought the Orange County Sheriff's Department Crime Laboratory only tested blood, not urine. That belief proved to be unfounded, as a crime lab

positive for methamphetamine and opiates.[5] A confirmatory test by means of gas chromatography/mass spectrometry (GC/MS) for methamphetamine was conducted on December 13, 2006, and on December 26, 2006, for opiates. The tests were positive for methamphetamine and Hydrocodone. Further confirmation was obtained by tests done on January 31 and February 9, 2007, which were positive for methamphetamine, Diazepam, Nordiazepam, Hydrocodone and Alprazolam.[6]

18. The Orange County District Attorney charged respondent with nine counts of Health and Safety and Penal Code violations. On September 7, 2004, in Orange County Superior Court case number 04WF1000 F A, respondent pled guilty to three counts: Health and Safety Code section 11377, subdivision (a), possession of a controlled substance, a felony; Health and Safety Code section 11550, subdivision (a), being under the influence of methamphetamine, a felony; and Penal Code section 374.3, subdivision (h)(1), dumping waste matter on private property, an infraction. The remaining six counts were dismissed as part of a plea bargain. In entering his plea, respondent specifically admitted: "On or about February 20, 2004 in Orange County, I willfully and unlawfully possessed a usable quantity of a controlled substance, to wit: methamphetamine, and was under the influence of the same. I also dumped waste matter in non-commercial quantities, unlawfully." Respondent signed the plea form immediately below the following printed language:

> I understand each and every one of the rights outlined above and I hereby waive and give up each of them in order to enter my plea to the above charge(s). I am entering a plea of guilty

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toxicologist confirmed otherwise. However, Officer Boldt's mistake was made in good faith and respondent did not establish any prejudice.

[5] The initial screening (immunoassay) test was not definitive for the presence of methamphetamine or any other drug. A screening test, if negative, eliminates the possibility of the presence of the drug. But to positively determine the presence of a drug, the screening test must be followed by a confirmatory test. As relevant to this matter, the confirmatory test was done by gas chromatography/mass spectrometry.

[6] At this hearing, respondent challenged the 2006/2007 confirmatory tests for methamphetamine on the ground that the blood sample had degraded over time and may have yielded false positive results. Due to respondent's guilty plea, the lab had not been required to perform the confirmatory tests earlier than December 2006, when the original toxicologist was contacted about testifying in this matter. Teresa Baisz, who has been a forensic scientist for the County of Orange for 17 years, testified that respondent's blood sample was properly stored and the three-year lapse of time did not affect the confirmatory tests she and another toxicologist conducted. Dr. James J. Carder, a dentist and registered pharmacist, testified that blood hemolysis (a term with which Ms. Baisz was not familiar) involves the rupture of red blood cells over time. Since the drugs involved attach to the cells, the drugs being tested for may be lost when the cells break down. Further, the testing of old blood may result in false positives. Dr. Carder cited national standards that indicate a frozen blood sample should not be used to test for the presence of drugs after four to five months. Dr. Carder has never performed any drug tests personally and is not a toxicologist.

The conflict in the expert testimony was resolved in complainant's favor. While Dr. Carder's theory concerning hemolysis cannot be discounted entirely, his lack of specific credentials on the subject of toxicology, combined with respondent's guilty plea, the finding of methamphetamine in respondent's wallet and respondent's admission to Officer Boldt that he took methamphetamine the night of his arrest provide overwhelming support for the conclusion that the blood test results reported by Ms. Baisz were accurate.

> because I am in fact guilty and for no other reason. I declare under penalty of perjury that I have read, understood, and personally initialed each item above and discussed them with my attorney, and everything on this form is true and correct. The signing and filing of this form is CONCLUSIVE EVIDENCE I have plead guilty to the enumerated charges herein.

(Emphasis in original.) Respondent was represented by counsel throughout the criminal proceedings.

The drug-related convictions are substantially related to the functions, duties and qualifications of the licensed activity.

19. As to the drug counts, entry of judgment was deferred and respondent was ordered to enroll in a drug program pursuant to Penal Code section 1000. He was advised that upon successful completion of the program, the plea could be withdrawn and the charges would be dismissed. Respondent was also ordered to pay fines and fees of $1,730 and to report to a probation officer "forthwith." Consistent with respondent's diversion into the drug program, sentencing was continued many times until, on June 14, 2006, respondent appeared and requested dismissal of the charges pursuant to Penal Code section 1000.3. At that time, testimony was taken from respondent that was found "not credible" by the sentencing judge, who concluded respondent was "unsuitable for continued Diversion." Instead, a probation report was ordered. On October 10, 2006, respondent was sentenced to three years of formal probation. He was ordered to obey all laws, to abstain from the use of unauthorized drugs, to submit to testing as directed by the probation officer or any police officer, to not consume alcohol and to submit to search by any law enforcement agent. Further, respondent was ordered to cooperate in any plan for psychiatric, psychological, alcohol or drug treatment or counseling, to attend and complete one Narcotics Anonymous meeting per day, to perform 200 hours of community service, to complete drug treatment and pay fines, costs and fees in the sum of $3,369.95. Respondent was also required to register as a narcotic offender under Health and Safety Code section 11590.

20. On April 27, 2007, respondent filed a motion to have the court declare the drug offenses misdemeanors under Penal Code section 17b. On September 27, 2007, Count 1, the possession charge, was reduced to a misdemeanor. On July 11, 2007, respondent filed a petition for dismissal under Penal Code section 1210.1, subdivision (d). At the time of this hearing, that petition was pending. Subsequent to the hearing, respondent submitted a copy of the minutes of the Superior Court dated November 2, 2007, indicating the petition was granted on that date.

21. Respondent testified that on the night of his arrest in Huntington Beach, the fast-food restaurant was busy, that he had ordered his food inside the restaurant and chose to wait outside by his vehicle while his food was being prepared. While waiting, he determined to apply paint remover with a Brillo pad to the left rear quarter panel of his pickup truck, an

area where his ex-girlfriend, Laila Nance, had "keyed" the truck. Respondent also accused Ms. Nance of "poisoning" him that evening, in an apparent attempt to explain his unsteady condition as noted by Officer Boldt. Respondent denied using methamphetamine at any time and he denied telling the officer that he had done so. Respondent said he did not know how the methamphetamine came to be in his truck. Respondent argued that Officer Boldt "lied" during his testimony. Respondent testified he pleaded guilty to the charges based on the judge's promise that they would be dismissed once he completed an eight-month drug class and community service.

22. Both Officers Boldt and Topartzer were credible witnesses. Officer Boldt's observations were timely recorded in his report. Respondent admitted at hearing that he never told the officers about his suspicions that Ms. Nance poisoned him or keyed his truck. He cannot be heard now to deny the import of his plea of guilty to the charges, particularly in light of his specific admissions made under penalty of perjury and with the advice of counsel. Just as the sentencing judge in the criminal case found respondent lacking in credibility, his explanation of his actions on the night in question offered in this hearing is not believable. The only believable explanation for respondent's conduct in the parking lot was that respondent was under the influence of methamphetamine, which was found in his wallet, and the use of which he admitted to Officer Boldt. The blood test results served merely to confirm respondent's guilt.

The 2001 Misdemeanor Conviction

23. On November 5, 2001, respondent was convicted on his plea of nolo contendere in San Bernardino Superior Court case number MNE009788, of violating Harbors and Navigation Code section 652, subdivision (c), reckless operation of a watercraft, a misdemeanor. The court in Needles fined respondent $821.

24. Although this conviction was pled as a ground for discipline and was alleged to be substantially related to respondent's activities as a dentist, complainant agreed at the hearing that there was not a substantial relationship, but asserted that the fact of the conviction was a ground to revoke probation because it represented respondent's failure to "obey all laws," and because respondent did not accurately report his address to the board. Both assertions will be discussed in connection with the Petition to Revoke Probation, *ante*.

Repeated Negligent Acts and/or Incompetence; Excessive Prescribing (The Third and Fourth Causes for Discipline)

25. Respondent is 41 years of age. He attended California State University, Long Beach, and San Diego State University before attending dental school at Boston College. Respondent initially practiced at his father's dental office in Bellflower. Since then, respondent has practiced dentistry in an office owned and operated by his father, Gerald Sandarg, at 19655 Harvard Place, Suite F, Irvine, California. Respondent's practice emphasizes complicated surgical procedures and implantology (surgery to implant teeth into bone), a field in which respondent is specially certified. In connection with the implant

surgeries, which respondent has performed approximately 240 times, a patient may be required to remain in the dentist chair eight or more hours. Many patients experience serious anxiety and require medication to calm them so that respondent may work on a patient who must remain very still.[7] The goal is not to put the patient to sleep, but to allow the patient to more calmly tolerate the extended procedure. Sedation of an anxious patient may be accomplished in two ways: intravenous sedation and oral sedation. Respondent has received training in "sedation dentistry," and practices only oral sedation, which achieves the desired effect of relieving patients of their anxiety by the prescription and/or administration of oral medication. Respondent's oral medications of choice to treat his patients' symptoms of anxiety are Valium (or its generic, Diazepam) and Xanax (or its generic, Alprazolam).

26. The number of tablets and their dosages given to a patient varies with the patient and depends on, among other considerations, the patient's individual tolerance to the particular medication. Therefore, the patient's prior experience in respondent's chair and the patient's stated history are important factors in determining the proper administration of the medication. Once sedated, the patient may request or otherwise demonstrate the need for more medication, which may be given to him or her in the judgment of the dentist, who must regularly monitor the patient for breathing, in particular. (An overdose of Valium or Xanax can depress the respiratory system.) There is no evidence that any patient under respondent's care has ever experienced a serious side-effect or respiratory depression while in his care.

27. (A) The routine utilized by respondent early in his practice of surgical dentistry was to give an anxious patient a prescription for the chosen sedative. The patient would then fill the prescription, take the recommended dosage prior to the procedure and keep the remaining pills for later in the procedure or for future appointments. Respondent found, however, that some patients appeared for their appointments without the medication and sometimes said it had been lost. Respondent initiated a different system to deliver the medications. The system in effect at all times relevant to this matter required patients to appear for their surgical appointments 30 to 60 minutes early and take a sedative provided by respondent or a staff member at respondent's direction. Respondent came to possess the drugs in one of two ways. Either he or staff ordered the medication directly from a distributor and had it available in his office, or respondent wrote a prescription for a patient and a staff member would take the prescription to a pharmacy, have it filled, and paid cash for the medication. This pharmacy run would occur while the patient was in the office, as the staff member usually obtained the patient's driver's license to take to the pharmacy. Patients were not billed for this service, nor, apparently, were they billed for the drugs when procured in this manner. Respondent testified that each individual prescription bottle was to be kept in a locked cabinet in his office for use only by that patient, as needed. Only respondent and his office manager, Laura Muniz, had keys to the cabinet.

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[7] Dentists may be certified to administer "conscious sedation" to patients to achieve a "minimally depressed level of consciousness produced by oral medication that retains the patient's ability to maintain independently and continuously an airway, and respond appropriately to physical stimulation or verbal command." (Bus. & Prof. Code, § 1647.18, subd. (c).)

(B) Laura Muniz combined the many bottles of Valium kept by respondent for various patients into one bottle she marked "Valium 10mg, Patient Distribution," sometime before March 1, 2005. The original label was obscured by the label Ms. Muniz placed on the bottle. Respondent testified, and Ms. Muniz agreed, that respondent became upset when he learned what Ms. Muniz had done. Respondent claimed that he was going to call the DEA and ask what to do about the situation, but the agency raided and searched his office before he had a chance to make the call.

Ms. Muniz testified initially that she had combined the pills into one container immediately before the search of the offices on March 1, 2005, or "perhaps one month before." On cross-examination, Ms. Muniz testified that she had combined the medications when she started keeping a log of sedatives given to patients in the office, which was on January 6, 2005, and that that was when she threw all of the original prescription bottles out and respondent had become angry. Thus, respondent likely knew of the combining of various patients' medications for two months before his offices were searched and the single container of Valium was found.

(C) Beginning in January 2005, staff maintained a "drug ledgor," [sic] which recorded the date, name of patient, drug dispensed, milligrams of the drug given and the patient's signature, for all drugs dispensed in the office. Before then, the dispensing of drugs, including sedatives, was sometimes, but not always, recorded in individual patient charts.[8]

28. The dental records of 17 patients of respondent were offered and received into evidence. The following five patients, all of whom expressed satisfaction with respondent's services, testified at the hearing.

(A) Patient I.G.[9] has treated with respondent for nine years and was happy with his treatment, which included cleaning, general maintenance and some implant work. He was given Valium to relieve his anxiety in connection with the implants, but he did not recall receiving a written prescription, nor did he go to any pharmacy to fill a prescription for Valium. He recalled that on one occasion one of respondent's staff went to a pharmacy to fill a prescription for him and that the staff member then dispensed the medication to him. He also recalls receiving additional Valium during an implant procedure after respondent asked whether he was feeling anxious.

(B) Patient H.C. has seen respondent for her dental needs since July 2004. She has received extensive treatment over 20 or 30 visits, including crowns, bridges and implants. In addition to antibiotics and pain medication (taken after some visits), respondent

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[8] Respondent's office records did include some handwritten entries in a journal that appear to represent respondent's record of drugs dispensed to patients from October 19, 2004, to January 25, 2005, which included dates, patient names and quantities and identities of medications delivered. No explanation was given for the temporal overlap in the two sets of records.

[9] Respondent's patients shall be referred to by their initials to respect their privacy.

prescribed Valium, which H.C. filled herself on most occasions. On other occasions, a member of respondent's staff, either "Helena" or "Kimberly," asked for her driver's license and then had the prescription for Valium filled. When that occurred, H.C. did not pay for the pills and was not given the prescription bottle at the conclusion of her visit. During the procedures, Valium was handed to H.C. by a "dental assistant," based upon orders of respondent, who periodically asked, "How are you doing?"

(C) Patient Lisa S. saw respondent for her dental work for five or six years. Her treatment included cleaning, crowns, fillings, extractions and implants. Lisa. S. arrived for her implant appointments 30 minutes early and was given Valium or Xanax for anxiety by the office manager, Laura Muniz, who was a long-time friend of Lisa S. The patient was told that a supply of drugs was kept for her at the office, although she also occasionally filled a prescription personally.

(D) Patient K.H. utilized respondent's services for over eight years. He had two implants as well as crowns, extractions, fillings and cleanings performed. Respondent's staff member Kimberly Moore performed teeth polishing, cleaning and x-ray services on K.H. Although K.H. recalled receiving prescriptions for antibiotics and pain medications, he did not recall receiving prescriptions for Valium or Xanax. However, he recalled being given something to relax him during an implant procedure.

(E) Patient L.M. utilized respondent's dental services between approximately 2000 and 2006 for her general dentistry needs. In 2005, L.M. was told she would be prescribed Valium to be taken prior to two scheduled root planing procedures. She called respondent's office in advance of the first procedure to inquire when the prescription would be called in to a pharmacy for her to pick up, and was told the drug would be provided and administered at the office. Upon arrival at the office, L.M. was handed two Valium pills by the receptionist (Helena) with a cup of water. Respondent was not present when the medication was dispensed. Additional Valium was dispensed during the procedure. This routine was repeated on the second visit. L.M. did not know if any member of respondent's staff obtained Valium for her at a local pharmacy and she was not offered the option of a written prescription. Weeks later, L.M. underwent a "bleaching routine" at respondent's office, after which respondent prescribed Hydrocodone, 15 tablets, for pain. The bleaching was done by a "girl" at the office. (At hearing, L.M. identified a photograph of Kimberly Moore as the person who performed the bleaching.)

29. The patient records contained the following information concerning the prescription and dispensing of Valium and Xanax by respondent.[10] (Entries in bold are from

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[10] These summaries are taken from the Accusation and the report of Dr. Larry D. Trapp (Exhibit 47). The details have been confirmed by a review of the records themselves. Respondent did not challenge the accuracy of these records, except with respect to whether certain dosages were given to patients at once or over the course of treatment on the particular day involved. The summaries in Finding 29 are not intended to resolve that dispute. Where a cell in the table is blank, the record did not reveal the information or it is not applicable to the particular entry.

pharmacy records, indicating prescriptions ordered by respondent but not recorded in the patients' charts.)

Patient Name	Date	Drug	Dosage (mg.)	No. of Tablets
1. I.G.	July 24, 2001	Xanax		
	October 4, 2001	Xanax	2	
	October 8, 2003	Valium	40	30
	October 15, 2003	Valium	30	
	February 18, 2003	Valium	10	
	March 16, 2004	Valium	30	
	November 11, 2004	Valium	30	
	December 2, 2004	Valium	40	
	January 6, 2005	Xanax	.10	
2. H.C.	January 25, 2004	Valium	10	30
	October 6, 2004	**Xanax**	**0.5**	**30**
	October 12, 2004	Valium	40	
	October 26, 2004	Valium	20	
	November 9, 2004	Valium	90	
	November 30, 2004	Valium	80	
	December 21, 2004	Valium	90	
3. L.M.	October 19, 2004	Valium	30	
	October 19, 2004	**Valium**	**10**	**30**
	October 26, 2004	Valium	30	
4. Lynne S.	**October 6, 2004**	**Xanax**	**0.5**	**30**

5. K.H.	September 24, 2004	Valium	80	
	October 5, 2004	Valium	20	
	October 20, 2004	Valium	20	
6. Lisa S.	February 5, 2002	Xanax	2	
	February 20, 2002	Xanax	1	
	March 13, 2002	Xanax	1	
	April 10, 2002	Xanax	0.5	30
	April 10, 2002	Xanax	2	
	March 26, 2003	Valium	80	
	May 15, 2003	Valium	10	20
	August 13, 2003	Xanax	0.5	30
	September 26, 2003	**Valium**	**10**	**30**
	October 29, 2003	Valium	20	
	January 13, 2004	Valium	20	
	April 27, 2004	Valium	60	
	August 18, 2004	**Xanax**	**0.5**	**30**
7. R.S.	**May 27, 2004**	**Valium**	**10**	**20**
8. H.P.	**May 6, 2004**	**Valium**	**10**	**20**
9. M.S.	**March 31, 2004**	**Xanax**	**0.5**	**30**
	April 29, 2004	Valium	60	
10. R.P.	September 4, 2003	Valium	20	
	September 10, 2003	Valium	20	
	October 30, 2003	Valium	50	
	November 13, 2003	Valium	40	
	December 4, 2003	Valium	40	

	January 7, 2004	Valium	30	
	January 7, 2004	**Valium**	**0.5**	**30**
	January 8, 2004	**Valium**	**10**	**30**
	January 9, 2004	Valium		2
	January 21, 2004	Valium	20	
	January 23, 2004	Valium	30	
	February 12, 2004	Valium	50	
	February 12, 2004	**Valium**	**10**	**30**
	February 20, 2004	Valium	40	
	March 5, 2004	Valium	50	
	March 26, 2004	Valium	80	
	May 14, 2004	Valium	10	
11. D.R.	**January 27, 2004**	**Xanax**	**0.5**	**30**
	January 28, 2004	Valium	20	
	February 20, 2004	Valium	20	
12. C.C.	February 22, 2001	Xanax	0.5	2
	March 29, 2001	Xanax	1.0	
	October 22, '02	Xanax	2	
	January 22, 2004	**Valium**	**10**	**30**
13. R.G.	**January 8, 2004**	**Valium**	**10**	**30**
14. H.M.	December 19, 2003	Valium	80	
15. M.P.	August 1, 2003	Xanax	0.5	30
	August 15, 2003	Valium	20	
	August 29, 2003	Valium	20	
	September 16,	Valium	20	

	2003			
	Sept. 16, 2003	Valium	10	
	October 10, 2003	Valium	20	
16. W.H.	September 11, 2003	Valium	40	
	September 11, 2003	Valium	20	
	September 11, 2003	**Valium**	**10**	**20**
17. J.R.	July 20, 2004	Valium		
	July 27, 2004	Valium	20	
	December 16, 2004	Xanax	1.0	
	January 11, 2005	Valium	30	

30. Complainant retained Larry D. Trapp, D.D.S., to review the patient charts and pharmacy records and to provide opinions in response to two questions posed: First, whether respondent's practice of having staff fill prescriptions for patients and maintaining their supplies of Valium and Xanax within the office for future visits was within the standard of care for dentists in the community? Second, was it within the standard of care to combine patients' pills into one container labeled "Valium 10 mg, Patient Distribution"?

31. Dr. Trapp is an Associate Professor of Dental Anesthesiology at the School of Dentistry, Loma Linda University, where he has been employed since 1993. Prior to that, he taught at Harbor-UCLA Medical Center. Dr. Trapp also maintained a private practice in dental anesthesiology from 1980 until 2004, which involved providing dental anesthesia services to fellow dentists in their offices. He has never practiced general or surgical dentistry.

32. Dr. Trapp testified that it was negligent for a dentist to maintain control of sedative medication such as Valium that had been prescribed for individual patients and to dispense tablets to them as needed. Dr. Trapp's primary concern was that security and record-keeping precautions would not likely prevent the diversion or alteration of the drugs. Dr. Trapp was also concerned about the status of pills remaining after patient care was completed. However, on cross-examination, Dr. Trapp agreed that there was nothing inherently wrong with someone other than the patient picking up a prescription from a pharmacy or for a dentist to pay for a patient's prescription. Dr. Trapp opined further that it was below the standard of care to maintain multiple patients' Valium pills in one container, because each filled prescription of tablets had a unique expiration date, and by combining the tablets the dentist would lose the ability to track the expiration dates. Furthermore, dentists

must follow certain procedures in the dispensing of controlled substances, which would be unreasonably complicated by combining the drugs.

33. Dr. Trapp's review of patient and pharmacy records resulted in his rendering opinions beyond the scope of questions originally asked of him. The additional opinions are summarized as follows:

(A) Dr. Trapp interpreted respondent's patient charts (as summarized in the table in Finding 29) to indicate that respondent was administering Valium and Xanax in single dosages. Only one chart entry specifically indicated that the total dosage recorded was given over time. That entry, for patient number 10, R.P., indicated that 80 mg. of Valium on March 26, 2004, was given to the patient over an eight hour period. No other chart entry for any other patient included that detail. In one entry for patient number 3, L.M., the chart clearly indicated the patient was given 30 mg. of Valium 20 minutes before her appointment. Under the assumption that all dosages not otherwise described as being given over time were single dosages, Dr. Trapp concluded that the pre-operative sedations were grossly excessive.

(B) Even if titrated (given over time, as needed), Dr. Trapp believed that 80 mgs. of Valium was a very large dose and unsafe.

(C) Dr. Trapp testified that prescriptions for 30 tablets of Valium, or Xanax, were excessive, regardless of whether they were titrated. In Dr. Trapp's opinion, three tablets of either drug would be sufficient to adequately sedate a patient for a single procedure. It is unnecessary and potentially dangerous to place 30 tablets of an addictive medication in the hands of a patient who does not need that many.

(D) Dr. Trapp noted that respondent prescribed pain medication for many of these same patients and believed that the potential for combining excessive doses of a sedative with opioids or alcohol could jeopardize a patient's health.

(E) Dr. Trapp noted that pharmacy records indicated a prescription for Xanax to patient number 4, Lynne S., on October 6, 2004, and that respondent's instructions were to take the medication "before bedtime." Dr. Trapp criticizes the use of Xanax as a sleep medication in a non-TMJ patient.

(F) Dr. Trapp expressed the opinion that respondent exhibited incompetence: 1) for repeated failures to make chart entries for the prescriptions found in pharmacy records; 2) for prescribing excessively large numbers of tablets; 3) for administering large doses of sedatives in single doses; and 4) for dispensing sedative drugs without following regulations that required, for example, offering a patient an alternative to receive a paper prescription.

(G) Respondent's prescription of opioid controlled substances (narcotics, or pain medications) and antibiotics for these patients was within the standard of care. Dr. Trapp agreed on cross-examination that the potential for abuse of narcotics was much greater than for sedatives and that sedatives in large doses may be safe for healthy people when they

are not taken in combination with alcohol or narcotics. Dr. Trapp also agreed that the recommended dosages vary among patients and depends to varying degrees upon a patient's weight, general health, level of anxiety and history with the chosen sedative.

34. Respondent offered the testimony of Stephen J. Nahigian, D.D.S., as an expert witness.

(A) Dr. Nahigian, who graduated from the University of Southern California School of Dentistry, practices oral surgery in Malibu. He is certified by the American Board of Oral and Maxillofacial Surgeons. Dr. Nahigian's certificate to practice was suspended by the board in 2005, following a second conviction for driving under the influence of drugs or alcohol. He is scheduled to remain on probation to the board until 2012.

(B) Dr. Nahigian testified that Valium and Xanax are widely used as sedatives for anxious patients and are extraordinarily safe so long as they are not combined with alcohol or other drugs. The oral form of the sedatives is especially safe, even in "huge" doses. Valium and Xanax, in oral form, have very little depressive effect on one's respiratory system.

(C) Dr. Nahigian based his opinions, in part, on an article that appeared in the *Journal of the California Dental Association* in August 2007, entitled "Overdose, Adverse Effects, and Safety of Oral Medications." The article discussed the use by dentists of benzodiazepines (including Valium and Xanax), which "are potent anxiolytic and hypnotic agents with anticonvulsant and muscle relaxant properties, commonly prescribed in dentistry for the treatment of dental anxiety prior to procedures." The article acknowledged the reality that dependence on such drugs is well-established and that a significant amount of abuse of these drugs is evident in society. But "death from oral administration of benzodiazepines alone is very uncommon." The article related that three individuals who ingested exceedingly large doses of such drugs, including one who took 200 to 1,000 times the recommended dose for sedation, recovered.[11] Dr. Trapp, complainant's expert, had not seen the article, but he agreed the Journal is peer-reviewed and authoritative.

(D) Dr. Nahigian emphasized that patients react differently to the drugs in question and that the dentist must determine as a matter of professional judgment the appropriate dose, taking into consideration the patient's weight, metabolism, and prior experience with the drug. So long as the patient is monitored for respiratory depression, Dr. Nahigian believed the administration of 80 mg. of Valium over an eight-hour period would present no danger to the patient.

(E) Dr. Nahigian further opined that respondent's practice of obtaining sedatives for his patients by having staff members fill a prescription, by directing an assistant to hand the pills to the patient and by maintaining individual patient prescription bottles in

[11] According to the article, the recommended dose of Diazepam (Valium) is 2 – 10 mg, as needed. For Alprazolam (Xanax), the dosage is 0.25 – 1 mg.

the office for the future use of that patient was within the standard of care. If drugs were purchased directly by a dentist, the standard of care required that dentist to keep a record of what was received, as well as what was dispensed. Dr. Nahigian opined further that the drug ledger kept in respondent's office after January 2005, was within the standard of care for recording the dispensing of drugs in a dental office. Dr. Nahigian agreed it was "a big mistake" to combine patients' pills into one container.

35. Conclusions reached regarding the First and Second Causes for Discipline are as follows.

(A) The facts did not demonstrate, by clear and convincing evidence, that respondent engaged in the excessive prescribing of sedatives to his patients. While the records could be interpreted to show that dosages were administered at once when not otherwise specified, testimony by patients and respondent make it equally likely that larger doses were titrated. The fact that no patient experienced any untoward side-effects, combined with the findings referenced in the recent journal article, supported the conclusion that respondent did not engage in over-prescribing. Much of the disagreement on this issue was the result of respondent's poor record-keeping, which did not make clear how drugs were administered or over what period of time.

(B) Respondent committed repeated acts of negligence with respect to his record-keeping. His records were barely legible and did not provide sufficient information to establish how sedatives were dispensed to his patients. In fact, on a number of occasions, medications prescribed for his patients were not noted in the patient charts at all, as shown by pharmacy records. The evidence also established instances of unsupervised dispensing of medications, by the receptionist and by the office manager, in the case of her friend, Lisa S.

(C) However, it was not shown by clear and convincing evidence that respondent's substandard record-keeping practices, amounted to incompetence.

The Possession of Controlled Substances or Dangerous Drugs by Respondent (Fifth and Sixth Causes for Discipline)

36. Respondent possessed an assortment of drugs when he was arrested by Huntington Beach police officers on February 20, 2004. In addition to the methamphetamine powder, a criminalist with the Huntington Beach Police crime lab identified the pills found in respondent's truck as follows:

1) 11 round, light blue tablets containing Diazepam (Valium);
2) 23 round, blue tablets containing Diazepam;
3) 34 round, light green tablets containing Diazepam;
4) 51 round, pink tablets containing Amitriptyline;
5) 8 blue capsules containing Flurazepam;
6) 118 pentagonal, pink tablets containing Methandrostenolone (anabolic steroid);

7) 25 round, white tablets containing Hydrocodone (Vicodin);
8) 86 round, green tablets containing Levothyroxine;
9) 45 round, tan tablets containing a thyroid hormone;
10) 12 oval, lavender tablets containing Alprazolam (Xanax);
11) 2 round, white tablets containing Cyclobenzaprine.

All of the pills identified, except those in items 4, 8, 9, and 11, contained controlled substances. Items 1 through 11 all required a valid prescription to possess.

37. In April 2000, Stephen Nicas became respondent's probation monitor. From sometime in 2001 to the present, Vicki Furtek has been his probation monitor. In August 2004, Mr. Nicas was assigned to investigate and make a recommendation to the AG concerning respondent. As noted, in September 2004, respondent pled guilty to possession of methamphetamine and to being under the influence of the drug. Thereafter, the investigative pace quickened.

38. Between December 2004 and February 2005, Mr. Nicas and an investigator for the Drug Enforcement Administration (DEA), Ronald Crabtree,[12] contacted, interviewed and obtained records from pharmacies in the area of respondent's office and home.[13] The investigators learned of respondent's office practice of obtaining drugs by office staff and paying for the drugs with cash. Pharmacists said it was highly unusual to dispense large quantities of Valium to dental patients (such as 30 tablets), particularly because the prescriptions directed the patients to take but one or two tablets before a procedure. Pharmacist Clifton Rose, who was the manager of the SavOn pharmacy next to respondent's office, once asked respondent about his practice. Respondent said large quantities were required for patients who were undergoing procedures over multiple appointments. Several patients identified from lists provided by the pharmacies confirmed that they were given two or three tablets before a procedure, but said they were not given their own prescriptions or bottles to take home following the procedure.

39. Records maintained by Blue Cross of California were obtained pursuant to a subpoena. They consisted of a spreadsheet of prescriptions filled at pharmacies for patient Scott W. Sandarg and paid for by Blue Cross. The spreadsheet listed 93 prescriptions filled for respondent from December 2001 to October 2004. The following table further summarizes the exhibit.

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[12] The DEA and investigator Crabtree had been involved in the earlier investigation that led to the 2000 administrative discipline of respondent.

[13] The pharmacy records obtained were of patients of respondent as well as respondent's own history of prescriptions filled at pharmacies. The records were voluntarily given over by the pharmacists. Neither the board nor the DEA obtained warrants or subpoenas in connection with this phase of their investigation, nor was any patient given notice of the investigators' intentions with regard to the records. Likewise, the doctors interviewed (see Finding 41) were not served with subpoenas nor was respondent noticed that patient information would be sought from them.

Prescriber's Name	First Prescription Dispensed	Last Prescription Dispensed	Number of Prescriptions Dispensed	Medications Prescribed
Richard C. Smith, MD	12/19/01	3/15/02	7	Vicoprofen
Euel King, DDS	2/19/02	7/3/03	16	Amitriptylin, Vicoprofen, Methocarbamol
Robert Comer, MD	2/19/02	10/14/04	28	Alprazolam, Lamisil, Levitra, Mentax, Propetia
Gerald Sandarg, DDS	4/11/02	10/20/04	13	Trimox, Vicoprofen, Methocarbamol, Prednisone, Amoxicillin, Hydrocodone, Cyclobenzaprine
Linh Vu Dinh, DDS	7/25/03	9/11/04	20	Hydrocodone, Cyclobenzaprine, Diazepam, Alprazolam
Scott W. Sandarg, DDS	4/11/02	10/20/04	9	Vicoprofen, Vioxx, Robaxin, Methocarbamol, Hydrocodone, Cyclobenzaprine

Respondent denied writing prescriptions for his own use and claimed that the records of Blue Cross were in error.

40. A "Patient Profile" was obtained from Walgreens Pharmacy in Huntington Beach by the investigators, and was authenticated at hearing by a Walgreens' pharmacist. The document was a computer printout of the history of respondent's medications dispensed at the Beach Blvd. location, and contained 21 prescriptions called in by Doctors Dinh, Comer and "Sandarg," between December 24, 2002, and September 10, 2004. The document does not include a first initial for "Sandarg," but copies of the actual prescriptions indicate they were written by "G. Sandarg," and called in by "Kim." The records also indicate that prescriptions written by Dr. Dinh were called in by "Kim."

A "Customer History Report" was obtained from a Rite-Aid Pharmacy in Irvine. The customer profiled was respondent. The report showed that on three occasions

between April 11, 2002, and January 13, 2003, respondent prescribed his own medications (Vicoprofen, Trimox, and Methocarbamol). Other prescriptions were ordered by respondent's father (four), Dr. King (two) and Dr. Comer (four), between April 11, 2002, and December 17, 2005. Respondent testified that the record of prescriptions written for himself were "misprints." He also speculated that his ex-girlfriend, who he said was a drug-abuser, may have used his prescription pad. (But respondent failed to explain why she would make the prescription out to respondent, and not herself.)

41. As a condition of his 2000 administrative probationary order, respondent was tested for drug use eight times between June 2000 and April 2003. Five tests were positive for anabolic steroids, Xanax, Oxazepam, benzodiazepines and/or Acetaminophen. Mr. Nicas asked respondent to provide him with evidence of prescriptions for those drugs. Respondent provided the names of several doctors who were subsequently interviewed by the investigators and called as witnesses at this hearing.

(A) Dr. Linh Vu Dinh is a dentist who has worked in respondent's office as an employee of Dr. Gerald Sandarg on a part-time basis since 2003. He became licensed in 2002. Dr. Dinh provided respondent general dental care and temporo-mandibular joint (TMJ) care for one year in 2003 – 2004, after Dr. King was no longer treating respondent. When shown respondent's pharmacy records that indicated he had written multiple prescriptions for respondent, Dr. Dinh told the investigators that he had written some, but not all of them. He specifically denied writing prescriptions for Valium, Flurazepam or Alprazolam. Dr. Dinh also told investigators that he did not take a history from respondent, and that respondent asked him for prescriptions for specific drugs. Dr. Dinh subsequently provided a list, compiled directly from his chart of his treatment of respondent, of the prescriptions for medications that were written for respondent during six visits over a 14-month period of time. The list read as follows:

7/25/03:	Vicoprofen (Hydrocodone) 20 tabs Robaxin (methocarbamol) 750 mg. 40 tabs Elavil 10 mg (tricyclic antidepressant) 15 tabs
9/12/03	Flexoril 10 mg (cyclobenzapine) 30 tab Vicoprofen 20 tab
2/27/04	Vicoprofen 20 tab
4/30/04	Flurazepam 10 tab
7/16/04	Vicoprofen 20 tab Flexeril 10 mg 3 tab
9/10/04	Valium 10 mg (diazepam) 30 tabs Vicoprofen 20 tabs

There were no refills indicated on the script.

A comparison of Dinh's personally prepared list with the Blue Cross records (see chart in Finding 39) yielded significant conflicts and supported Dr. Dinh's initial statement that he did not write all of the prescriptions contained in the pharmacy records. In fact, Dr. Dinh told investigators that he felt respondent was using him to obtain drugs. In a letter written at the request of respondent's office manager, Dr. Dinh denied forming the opinion that respondent was a "drug abuser." At the hearing, Dr. Dinh claimed he was "jet-lagged" when he was interviewed by Messrs. Nicas and Crabtree.

(B) Dr. Euel King has been a dentist since 1959 and a friend of respondent and respondent's father for many years. When shown records by the investigators, Dr. King said that he saw respondent as a patient for TMJ problems on one occasion only, when he prescribed a muscle relaxer and Vicodin for pain. However, Dr. King apparently did not maintain a chart regarding his care and treatment of respondent. In an "affidavit" prepared by Mr. Nicas and signed by the witness, Dr. King stated:

> I wrote prescriptions as a friend not because he was a patient, based on telephone calls from Dr. Scott Sandarg. After receiving so many telephone calls from Dr. Scott Sandarg requesting prescription drugs I had to tell Dr. Scott Sandarg that I could no longer prescribe drugs for him. I believe Dr. Scott Sandarg was using me to get drugs.

In a subsequent letter written at respondent's request, Dr. King said he did not mean to insinuate that respondent had a drug problem. On cross-examination, Dr. King indicated that Mr. Nicas had prepared the affidavit, but he also admitted, "I told him all this."

Dr. King is 77 years old and was an unreliable historian. In fact, his daughter accompanied him to the hearing and was called as a witness. She testified that her father has had memory problems for the past five years.

(C) Robert Comer, M.D., is a board-certified internist and respondent's personal physician. On July 19, 2000, Dr. Comer wrote: "Scott Sandarg is under my care for stress-related anxiety. His overall basic health is considered good." Dr. Comer first treated respondent in January 2000, when respondent complained of stress and elevated blood pressure, although his blood pressure was normal on that first visit. At that time, respondent's testosterone level was lower than normal, but it was well above normal when checked again in March 2002 and in October 2004. Dr. Comer told the investigators on December 22, 2004, that respondent's elevated testosterone levels could not have been achieved naturally. When respondent was asked by Dr. Comer sometime between 2002 and 2004, if he was taking steroids, respondent denied it. Dr. Comer was not aware of respondent's steroid-taking until July of 2007, when respondent told him that he was receiving hormone replacement therapy, in the form of steroids, from the Palm Beach

Rejuvenation Center in Florida. Nevertheless, Dr. Comer believed that the diagnoses reportedly made by doctors in Palm Beach (early andropause, [14] pituitary insufficiency and testicular insufficiency) were consistent with his own lab test results.

Over the years, Dr. Comer made the following diagnoses of respondent: stress, hypertension (by report of his patient), hypothyroidism (by family history), thyroiditis, onichomycosis, dermatitis, alopecia, elevated cholesterol, irritable bowel syndrome, renal insufficiency, C-5/C-6 ruptured disc, gastritis, colitis, and depression. He prescribed multiple medications. Dr. Comer's records were not placed into evidence, but his testimony regarding the prescription history is summarized in the following table.[15]

Date	Drug	No. Tabs	Reason
January 2000	Inderol 10 mg		Blood pressure
August 2001	Xanax		Anxiety
February 2002	Xanax		Anxiety
March 2002	Xanax	100	Anxiety
April 2002	Lamicil		
June 2002	Lamicil		
August 2002	Xanax	90	Anxiety
August 2002	Lipitor		Cholesterol
February 2003	Xanax	90	Anxiety
July 2003	Xanax	90	Anxiety
October 2003	Propetia		
October 2003	Lovitra		E.D.
April 2004	Xanax		Anxiety
October 2004	Xanax	90	Anxiety
February 2006	Xanax	45	Anxiety
February 2006	Ambien	(2 refills)	Insomnia
April 2006	Hydrocodone/Ibuprofen		Cervical pain
May 2006	Xanax	45 (2 refills)	Anxiety
June 2006	Hydrocodone/Ibuprofen	(2 refills)	Cervical pain
August 2006	Xanax	45 (2 refills)	Anxiety
August 2006	Ambien	(2 refills)	Insomnia
November 2006	Xanax	45 (2 refills)	Anxiety
December 2006	Xanax	30 (1 refill)	Anxiety
February 2007	Xanax	30 (refill)	Anxiety
March 2007	Ambien	(2 refills)	Insomnia
April 2007	Xanax	30	Anxiety
June 2007	Xanax	30 (2 refills)	Anxiety

[14] Andropause is male menopause.

[15] The information in the table is gleaned from notes taken during Dr. Comer's testimony and is consistent with information found in pharmacy records. It is not relied upon in reaching any findings or conclusions except in a very general way.

July 2007	Ambien	30 (2 refills)	Insomnia
July 2007	Hydrocodone/Ibuprofen	30 (5 refills)	Cervical pain

In August of 2007, Dr. Comer denied respondent's request to refill a Xanax prescription. Although Dr. Comer subsequently prescribed Hydrocodone for respondent's cervical pain, he told investigators on December 22, 2004, that respondent had not made any complaints to him about any pain or discomfort that would require narcotics.

(D) Gerald Sandarg, D.D.S., is respondent's father. He practices general dentistry at 17024 S. Clark Street, Bellflower, California, and is also the responsible manager of the Irvine location where respondent practices. Gerald Sandarg currently works out of the Irvine office one day per month. Respondent and his various assistants in Irvine are employed by Gerald Sandarg, but Dr. Gerald Sandarg testified he was not personally familiar with the methods of dispensing medications at the Irvine location.

Dr. Gerald Sandarg treated respondent for "severe TMJ dysfunction" for many years and he wrote prescriptions for that condition. He said his son has suffered from intractable headache pain.

Respondent's father was interviewed by Mr. Nicas and Mr. Crabtree in 2005. When shown copies of drug invoices found in respondent's garage that were in his name, Dr. Gerald Sandarg told the investigators he had not ordered "all those drugs." At hearing, Dr. Gerald Sandarg denied making that statement. He testified that he lacked storage space at his own office and had stored some documents at his son's home.

Dr. Gerald Sandarg believed the charges concerning his son's drug abuse were "totally false and ludicrous. [The DEA and Dental Board's] raid on my office will be costly to them when the false arrest judgment is returned upon the completion of my multimillion dollar law suit against all of them."[16]

(E) Following the positive urine tests for anabolic steroids and in response to Investigator Nicas' August 2002 request that he provide proof of valid prescriptions for the substances, respondent sent Mr. Nicas a letter on the letterhead of Palm Beach Rejuvenation Center, Inc., of Jupiter, Florida. Undated and unsigned, the letter purported to be from "Joseph Raich, Vice-President." Mr. Raich is neither a dentist nor a physician. The letter stated:

> Scott Sandarg is a current patient with Dr. Jim D'Amico at the Palm Beach Rejuvenation Center. Mr. Sandarg is currently undergoing hormone replacement therapy for low testosterone levels and nanralone deconate for joint aches. If you have any questions please call our office.

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[16] Dr. Gerald Sandarg made this statement in a letter "to whom it may concern." (See Exhibit I.)

Respondent later forwarded what he called "updated information" to Mr. Nicas in the form of another letter from Florida. The letter was nearly identical to the earlier letter from Mr. Raich, except it was from Dr. D'Amico. The essential difference in the two letters was that the D'Amico letter specified the dosages of the medications being prescribed. Respondent told Mr. Nicas in April 2003, that he had gone to Florida before receiving any prescriptions from the Palm Beach Rejuvenation Center, and that he saw Dr. D'Amico. No one from the Palm Beach Rejuvenation Center testified at the hearing.

Respondent also said he had previously obtained steroids through a website known as "Lifespan," and provided a July 2000 letter that read:

> Scott Sandarg is a patient undergoing Testosterone Replacement Therapy pursuant to a prescription issued by medical doctors in the United States. The patient is required to apply transdermal cream on a daily basis and therefore may be required to travel with the prescribed pharmaceuticals and syringes.

The letter, addressed "To Whom It May Concern," was signed by "Merton Shure, MD." The letterhead read, "LifeSpan Longevity Centers." In an interview in April of 2003, respondent said that he started using steroids obtained through Lifespan in 2001, and that Lifespan was located in Georgia. Respondent had never visited Lifespan in Georgia, but did go to an "associated" office in Long Beach for blood tests. He could not remember if a doctor was present. According to respondent, Lifespan relied on Dr. Comer's diagnoses in supplying the drugs. The "medical doctors in the United States" referred to by Dr. Shure as having prescribed steroidal therapy were not identified by respondent.

42. Based on investigator Nicas' suspicions that respondent obtained and used controlled substances without valid prescriptions, and that he was diverting drugs from patients for his own use, Mr. Nicas applied for and obtained a search warrant, signed by a Superior Court judge, to conduct searches of respondent's office, residence and vehicle. In concert with the DEA, which obtained its own Warrant for Inspection from the United States District Court, the search warrant was executed on March 1, 2005. Several board investigators and several DEA investigators entered the Harvard Place office and "secured the location," meaning that staff members were not allowed to leave or use the phones. The board investigators who entered the office were carrying pistols, but did not remove them from their holsters.[17] The front and back doors were locked and neither staff nor patients

[17] Board investigators are sworn peace officers and are permitted to carry firearms. DEA investigators are not. The various witnesses recall the details of the "raid" differently. Respondent and members of the office staff testified that the agents came in with guns drawn, pointed toward the floor. The several agents who testified, including Mr. Nicas, were adamant that their weapons were not drawn. All agreed the board's agents wore vests that identified them as "police," and that the office was secured quickly upon their entry. It is not surprising that witnesses may have seen guns in holstered positions, but after experiencing the "rush" of a police-type raid, recalled that the guns had been drawn. These memories would be reinforced as the witnesses relived and recounted the events over the ensuing months and years. But Mr. Nicas and the other members of the team were adamant and credible on the subject of the use of weapons, and it is found that they were not drawn at any time during the search of the office premises.

were permitted to leave until they were identified and interviewed. These individuals were temporarily sequestered in individual offices and examining rooms. Board investigators testified that their actions in securing the location constituted a routine method used by peace officers to protect themselves and others from potential harm, even though they had no information that respondent or any of the office personnel represented a specific threat.

43. The DEA was in charge of the search of the office. Found in respondent's corner office were multiple single bottles of prescription medications, including:

Drug	No. of Tablets	Prescribed By	Prescribed For
Valium 10 mg.	274		"Patient Distribution"
Diazapam 10 mg.	458	Manufacturer's bottle	
Alprazolam 1 mg.	50	Manufacturer's bottle	
Hydrocodone 10-500 mg.	23	Manufacturer's bottle	
Ibuprofen 7.5 mg.	1	Dr. Linh Vu Dinh	Respondent
Diazepam 10 mg.	15	Respondent	Patient I.G.
Alprazolam .5 mg.	3	Dr. Robert Comer	Respondent
Alprazolam .5 mg.	50	Comer	Respondent
Alprazolam .5 mg.	0	Manufacturer's bottle	

Mixed in with the Ibuprofen prescription bottle were one yellow tablet ("Watson 853") and one unidentified blue tablet. Mixed in with patient I.G.'s prescription bottle of Diazepam green tablets was one unidentified blue tablet. Mixed in with respondent's prescription bottle of Alprazolam was one unidentified white tablet.

Also seized at respondent's office were pages printed from the website, "AnabolicSteroids.com." Touted as "The Steroid Bible," the literature included information on "How to get steroids legally," "Doctor recommended dosages for over 19 different kinds of anabolic steroids," and "How to pass drug tests for steroids and other drugs." Finally, the patient files listed in Finding 29 were also seized.

44. Board investigators were in charge of the search of respondent's home at 465 Giotto Place, Irvine, and his vehicle. Found were the following:

(A) Numerous vials of anabolic steroids, including:

No. of Vials or Bottles	Drug	Prescribed By	Prescribed For	Where Found
Four full, two empty	Somatotropin, 9 mg	Dr. Derek Vigil	Respondent	Kitchen refrigerator
Two	Nandrolone Deconoate, 200	Vigil	Respondent	Kitchen refrigerator

	mg.			
Two	Testosterone, 200 mg.	Vigil	Respondent	Kitchen refrigerator
One	Stanozolol, 50 mg.	Vigil	Respondent	Kitchen refrigerator
Three	Trimix	Vigil	Respondent	Kitchen refrigerator
One (empty)	Clomiphene Citrate, 51 mg.	Vigil	Respondent	Kitchen
One (empty)	Norco 10/325	Vigil	Respondent	Bedroom
One (empty)	Oxandrolone, 12.5 mg.	Vigil	Respondent	Bedroom

(B) Numerous bottles of controlled substances, including:

No. of Tablets in Bottle	Drug	Prescribed By	Prescribed For	Where Found
5	Diazepam, 10 mg.	Dr. Linh Vu Dinh	Respondent	Kitchen
0	Flurazepam, 30 mg.	Dinh	Respondent	Bedroom
0	Alprazolam, .5 mg.	Dr. Robert Comer	Respondent	Bedroom
10	Hydrocodone	Dr. Jeffrey White	Respondent	Bedroom
1	Alprazolam	(Manufacturer's bottle)		Bedroom
55	Alprazolam	(Manufacturer's bottle)		Bedroom
0	Hydrocodone	Dinh	Respondent	Living Room
0	Cyciobenzaprine	Dinh	Respondent	Living Room

(C) Other items, including:

No. of Item Found	Description of Item	Where Found
27 pages	Invoices from Henry Schein, New York, for drugs billed to Gerald Sandarg, DDS	Bedroom
Unknown	Syringes	Refrigerator
3	Yellow/brown capsules	Living Room
1	Gold capsule	Living Room
3	Urine/Saliva/Blood Cleansers	Living Room

1	"Test Pure; All-In-One Cleansing Shampoo"; "Cleanses Toxins"	Living Room
1	"P-Sure" Synthetic Urine	Garage
3	Whizz Pack; "Complete Urine Substitution Kit"	Garage
Misc.	Pills in plastic bag	Garage
91	Syringes	Garage
11	Needles	Garage
3	Syringes (used and capped in a liquid, Papaverine)	Garage refrigerator
1	Notebook, including handwritten lists of internet drug sites, such as "drugstore.com," "MondoRx.com" and "CanadianRx.com"	Garage
1	Dental Chart for Patient I.G.	Vehicle
1	Dental Chart for Patient C.C.	Vehicle

Henry Schein is a national pharmaceutical distribution company. The shipping invoices found in respondent's garage indicated that between June 2004 and November 2004, approximately 4,000 tablets and Schedule III and Schedule IV controlled substances, including Xanax, Alprazolam, Daizepam and Hydrocodone, were shipped to Gerald Sandarg at 17024 Clark Street, Bellflower.

45. Board investigator Nicas arranged for an officer of the Irvine Police Department to be present during the search of respondent's home. The officer allegedly had special training in determining whether an individual is under the influence of controlled substances. As a result of an interview of respondent, the officer arrested respondent. Subsequent testing, however, was negative for drugs and the Orange County District Attorney declined to press charges.

46. Investigators Nicas and Crabtree interviewed respondent on March 29, 2005, in the presence of his attorney. Respondent stated he had been treated by Dr. Derek Vigil of the Palm Beach Rejuvenation Center for about four years, or since the time he traveled to Florida to begin his treatment of hormone therapy. He did not remember Dr. D'Amico. (In an interview of March 29, 2005, respondent specifically denied meeting D'Amico.) Respondent said he received anabolic steroids for "anti-aging" and hormone replacement therapy. Respondent claimed to have seen Dr. Vigil when he visited the Center four years before, and that Dr. Vigil conducted a full physical examination and obtained blood for lab work. However, when questioned by investigators in February 2004, respondent said he saw Dr. D'Amico in Florida, and he did not mention Dr. Vigil.

Lab work was also done through Dr. Comer and forwarded to Florida. (This testimony was confirmed by Dr. Comer.) Respondent admitted obtaining Hydrocodone over

the internet (www.norcoworldwide.com) on one occasion for severe pain. He did not recall who the prescribing doctor was for this drug.

47. Respondent testified that a friend named Bob Short referred him to the Palm Beach Rejuvenation Center. Respondent was suffering from sweats, low sex drive and loss of weight. (Respondent did not explain why he had not treated for these complaints with his primary care physician, Dr. Comer.) Respondent performed research over the internet concerning steroids because he was aware of the dangers and "didn't want to die." He has not seen any Palm Beach Rejuvenation Center doctor since his only visit there four years ago and has never met or spoken with Dr. Carlson, the most recent treating physician from that center. Respondent maintained that he took no steroids that were not prescribed, but he declined to give the board investigator permission to obtain Florida records. Respondent also testified that the syringes found in his home were prescribed by the Palm Beach Rejuvenation Center and obtained through a Florida pharmacy.

48. With regard to the devices found in his house and garage that appeared to be kits designed to defeat a urine test (urine "cleansers, "P-Sure," and "Whizz packs), respondent testified that two or three of the kits were given to him by a friend named John Lennon, and that the others belonged to Mr. Lennon. Respondent claimed he never used the products, but did not explain why he would accept such gifts from his friend.

49. In connection with the Orange County criminal case, a Dr. Robert G. Carlson, M.D., Medical Director of the Palm Beach Rejuvenation Center, wrote an undated letter to a Judge Rodriguez that read:

> Scott Sandarg has been a patient through Palm Beach Rejuvenation Center since March 2003. He is prescribed testosterone, testosterone derivatives and human growth hormone for symptoms related to early andropause, pituitary insufficiency and testicular insufficiency. Each aforementioned, prescribed, medication requires a needle/syringe for application/administration. Mr. Sandarg is sent the required application needle/syringes with each of these medications via Signature Pharmacy, Orlando, FL. Copies of all Mr. Sandarg's prescriptions can be made available with proper release of medical information documentation. All needle/syringes sent to Mr. Sandarg also have corresponding written prescriptions on file.

50. At hearing, respondent offered copies of prescription labels, evidencing prescriptions filled for anabolic steroids at pharmacies in Florida and Alabama. The prescriptions were usually written by Dr. Vigil, but prescriptions were also written by Dr.

D'Amico ("DDS, MD") and Dr. Carlson. Dr. D'Amico is licensed as a dentist in Florida, but he is not a licensed physician in that state, despite his use of "MD" after his name.[18]

51. Respondent told investigators he saw Dr. Euel King every four months for two or three years, although his last prescription from Dr. King was "years ago." Respondent said his father treated him for years, but never prescribed medications for him. Further, respondent stated he was treated by "Dr. Vu" for TMJ problems every three or four months.

52. Clear and convincing evidence established that respondent illegally obtained and possessed multiple controlled substances and dangerous drugs. The following paragraphs summarize the facts that lead to this conclusion.

(A) Huntington Beach police officers found 415 pills that required prescriptions in respondent's truck on February 20, 2004. Respondent correctly argued that it is not unlawful to combine one's own medications into one container so long as each drug is possessed pursuant to a lawful prescription and that one is not required to carry his prescriptions with him. But respondent offered no credible explanation for the tremendous quantity of drugs found in his vehicle. The records showed that the most recent prescription for either Diazepam or Alprazolam before February 20, 2004, was written in July of 2003, when Dr. Comer prescribed 90 tablets of Alprazolam to respondent. (The bottle of 415 pills included 12 tablets of Alprazolam.) *No* prescription for Diazepam for respondent was found in the records before February 20, 2004, and yet respondent possessed 68 tablets of that drug when arrested.

(B) Somehow respondent obtained Diazepam based upon prescriptions written in the name of Dr. Dinh, but Dr. Dinh did not write any prescriptions for that drug for respondent.

(C) On at least nine occasions, respondent wrote prescriptions for different drugs, most notably the pain-killer Vicoprofen, for himself.

(D) Respondent possessed two bottles containing 56 tablets of Alprazolam in his home. Those were manufacturer's bottles and represented drugs that were not intended for the use of patients in the office, where they were required to be kept. On the same day, respondent had two other manufacturer's bottles of Alprazolam at his office, one of which was empty. There is no plausible explanation for this arrangement other than that respondent kept the drug at home for his own use.

(E) The allegation that the Henry Schein drug invoices found in respondent's home established that respondent obtained or possessed the 4,000 pills represented by those invoices is not sustained. Although it is certainly suspicious that the invoices in his father's

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[18] Respondent objected to the introduction of certified copies of Florida License Certifications (see Exhibit 43). The objection is overruled. The documents are received as official records under Evidence Code section 1280 and given the benefit of the presumption created by Evidence Code section 664.

name were found in respondent's bedroom, and even though Gerald Sandarg's explanation that he needed to store 27 pages of documents there was a dubious one, the invoices indicate that the drugs were shipped to the Bellflower office of Gerald Sandarg and there was no evidence directly placing the drugs in respondent's possession at any time.

(F) Respondent's explanations for his possession and use of anabolic steroids and the needles associated with their use lacked credibility. In addition to his admission that he had obtained Hydrocodone over the internet without a prescription, respondent gave significantly varying and incomplete answers when questioned by board investigator Nicas about the presence of steroids in his system, which were evident in random drug tests conducted as early as April 2001. Respondent claimed he visited the Palm Beach Rejuvenation Center during that time, but offered nothing to corroborate that claim, such as a record from the Center indicating his presence there, a travel itinerary or records of expenses made on the trip. Respondent's "research" and prior history with internet steroid procurement supported the conclusion that respondent did not undergo a good faith medical examination before obtaining steroids from the Center. Respondent admitted that he never saw either Doctor D'Amico, the individual initially named as his treating physician, or Dr. Carlson, the physician who most recently reported on respondent's condition.

Respondent was and is aware that no medical doctor provided him with a valid prescription for anabolic steroids. His testimony that the LifeSpan internet source of steroids found legitimacy in diagnoses made by his primary care physician was not credible. Dr. Comer did not diagnose early andropause, pituitary insufficiency or testicular insufficiency. In fact, when he was asked by Dr. Comer about his elevated testosterone levels, respondent initially denied he was taking steroids. The LifeSpan-dispensed steroids were obtained in 2001, years before Dr. Comer became aware that respondent was taking steroids or claimed to be suffering any condition requiring their use. Dr. Comer did testify, well after the fact, that respondent's lab findings were consistent with the diagnoses allegedly made in Florida, but that testimony did not adequately substitute for good faith diagnoses based upon physical examination, laboratory results and considered medical judgment.

Lastly, the very possession by respondent of devices and kits designed to fool urine tests for steroid use cannot be ignored in assessing respondent's credibility and true intentions on the steroid issue. The casting of blame for ownership of the items on a "friend," like the blame cast on his ex-girlfriend for keying his car, poisoning his coffee with methamphetamine, and using his prescription pad to obtain drugs, was too convenient and would convince only the most naïve of respondent's blamelessness.

Respondent Administered Controlled Substances to Himself (Seventh and Eighth Causes for Discipline)

53. Respondent self-administered methamphetamine (see Findings 13 to 18 and 22), a controlled substance and dangerous drug.

54. As referenced in Finding 41, respondent was tested for the presence of drugs on eight occasions when he was on probation with the board. On five of those occasions, respondent tested positive, as follows:

Test Date	Result
4/6/01	Positive for anabolic steroids and Xanax
11/08/01	Positive for Oxazepam
4/23/02	Positive for Benzodiazepines
11/13/02	Positive for anabolic steroids and Xanax
4/23/03	Positive for Benzodiazepines and Acetaminophen

(The tests for anabolic steroids were indicated as positive due to the high testosterone levels detected.)

55. Complainant offered the testimony of Frederick Fung, M.D., who is a member of the Sharp-Stealey Medical Group since 1988, and is its Medical Director of Occupational Medicine and Chief of Toxicology. Among Dr. Fung's duties is to evaluate patients for exposure to drugs or toxins. He is board-certified in Medical Toxicology and Preventative Occupational Medicine.

(A) Dr. Fung opined that the use of anabolic steroids may lead to many serious side-effects, including organ failure, immune dysfunction, cancer, stroke, thrombosis, heart attack, and decreased tendon strength. Therefore, the use of such drugs must be carefully prescribed and administered. Concerning the specific steroids possessed and used by respondent, Dr. Fung offered the following observations.

(1) Somatotropin is approved by the Federal Drug Administration (FDA) only for renal failure in HIV-related cases. It is believed by some to enhance athletic performance, but there is no true science supporting this claim.

(2) Testosterone Prop is a steroid in the same class as Nandrolone Deca, Stanozolol, Testosterone Cyp/prop and Oxandrolone, used for the treatment of hypogonadism. Nandrolone is approved by the FDA for treatment of anemia and renal insufficiency. Stanozolol is for "hereditary anioedema prophylaxis." Axandrolone is to treat bone pain secondary to osteoporosis. These drugs are also used by some to enhance athletic performance, but at substantial risk to their long-term health.

(3) Clomiphene Citrate is an estrogen receptor that is approved to treat ovulatory dysfunction in females. The drug has also been used to improve male fertility, but is not FDA-approved for this use. In fact, chronic use of anabolic steroids may lead to male infertility.

(4) Papaverine is a vasodilator approved for the treatment of vasospastic disease. When mixed with Norco, or Hydrocodone, it is used for prolonged pain relief, although such use is not FDA-approved.

(5) Dr. Fung agreed that it is not "illegal" for a doctor to prescribe a drug for an "off-label" use if, in the judgment of the prescribing doctor, the use will benefit the patient.

(B) Dr. Fung is believed that if respondent were required to take the various steroids and other drugs allegedly prescribed for "early andropause, pituitary and testicular insufficiency," then respondent would be "a very sick man." Dr. Comer's testimony did not support such a conclusion.

(C) The use of benzodiazepines, such as Xanax or Valium, may be used to counter the aggressiveness or irritability that may accompany the use of anabolic steroids. The use of several Schedule III (steroids) and Schedule IV (benzodiazepines and opioids) drugs, in combination, may lead to a high potential for physical and psychological dependence and addiction, as well as have the potential to "multiply" the effects of the opioids.

(D) Dr. Fung reviewed the list of medications prescribed to respondent according to the Blue Cross records (see Finding 39). Dr. Fung noted the prescription for Amitryptyline, which may have an adverse impact on one's heart. He also noted several prescriptions given on the same day, indicating a combination of drugs taken simultaneously, including muscle relaxers (Robaxin, Methocarbamol and Cyclobenzaprine) and opioids and sedatives. If respondent was or is taking the many medications on the list, then, in time, the practice will be injurious to his health.[19]

(E) Dr. Fung opined that the ingestion of steroids and other controlled substances is prima facie evidence of drug abuse. But the witness would defer to a psychiatrist to aver whether respondent, in particular, is a danger to himself or others.

56. Respondent countered with the testimony of James J. Carder, D.D.S. Dr. Carder is a dental surgeon and registered pharmacist. He has been a staff dentist at the University of California at Riverside for 33 years. Dr. Carder was retained by the board on 50 occasions to render expert opinions. Dr. Carder rendered these opinions:

(A) Respondent's medical conditions justified the prescriptions for steroids. These conditions, including low levels of testosterone and hormonal imbalance, specifically

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[19] During his testimony, the witness misinterpreted the Blue Cross records. In the column labeled "Day Supp," Dr. Fung felt the number 10, for example, corresponded to the number of pills to be taken daily. The parties agreed that the abbreviation actually refers to a "10-day supply" in the example. Dr. Fung later testified that the different interpretation would make no difference in his opinions.

in the thyroid,[20] were confirmed by Dr. Comer. Dr. Carder did not find evidence of over-prescribing or abuse of these substances.

(B) Dr. Carder testified that it is difficult to fill an out-of-state prescription in California.

(C) A pharmacist should not/would not fill a prescription for drugs intended for the prescriber's use without putting his own license in jeopardy.

57. Based upon the conclusions reached in Finding 52, the additional conclusion that respondent administered controlled substances to himself, and used controlled substances in a dangerous manner, is inescapable. Without diminishing Dr. Carder's credentials or breadth of knowledge, as a dentist and pharmacist he did not diminish the testimony of Dr. Fung, a physician and board-certified toxicologist. And despite the lack of evidence of any serious, negative side-effects, or evidence that respondent's abuse of controlled substances has hampered his ability to work safely to this point, expert testimony was not required to reach the common sense conclusion that respondent has engaged in very dangerous conduct by reason of his abuse of controlled substances. If unabated, the danger will result in serious health risks to both respondent and to his patients.

Failure to Follow Prescription and Dispensing Procedures (Ninth Cause for Discipline)

58. Complainant called Daniel Hancz, Ph.D., as an expert on the standard of care for a "dispenser" of controlled substances. Dr. Hancz, who holds a doctor of pharmacy degree from the University of Southern California, has been a registered pharmacist since 1988, and has worked for the Los Angeles Department of Public Health for 21 years. He is currently its Pharmacy Director and is familiar with the codes and regulations that govern the proper purchase, acquisition and dispensing of controlled substances and dangerous drugs. He is an advisor to a task force that investigates fraud and the unlicensed dispensing of drugs. He has worked closely with the board in previous investigations. His opinions closely mirrored the statutory provisions alleged in the Ninth Cause for Discipline, as follows.

(A) The standard of care for a dispenser of drugs requires that the dispenser comply with certain record-keeping requirements. Specifically, a dentist who purchases drugs must keep a record of the name and address of the supplier, the date of purchase of the drugs, the name and quantity of the drug, which information must be kept at the buyer's business address.

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[20] Dr. Carder's opinion in this area was permitted based upon his experience as a pharmacist and dispenser of medications, not as a dentist. The witness testified that he has not actively dispensed medications as a pharmacist for 20 years.

The evidence did not support a finding that respondent violated this requirement. The board and DRE agents who searched respondent's office did not report the lack of the required records in the office location. Rather, the facts relied on regarding this opinion (and the allegation in the Accusation at page 25, paragraph 66(a)) appear to concern the many pages of invoices from drug distributor Henry Schein, which indicate drugs were ordered by Dr. Gerald Sandarg. Complainant did not establish by clear and convincing evidence that respondent illegally used his father's DEA number to procure those drugs. Any failure to comply with the law concerning where such records were kept is Gerald Sandarg's responsibility.

(B) A dispenser of drugs may not re-label a manufacturer's bottle of drugs unless all of the original label information is clearly visible. The standard of care for a dispenser of controlled substances and dangerous drugs requires that he fulfill all labeling and record-keeping requirements imposed on a pharmacist. Drugs obtained by the dispenser in manufacturers' containers must devise and maintain an accounting of drugs received and dispensed.

Respondent's officer manager combined patients' Valium into one large bottle, which was a manufacturer's bottle (see Finding 27(B)); doing so violated the standard of practice for a dentist, as well as Business and Professions Code section 4060. Respondent did not dispute this conclusion.

(C) The standard of care for a dispenser of drugs does not permit a non-licensee (in this case, a non-dentist) to physically be the one to hand drugs to a patient.

Dr. Nahigian, on the other hand, testified that it was within the standard of care, and was common practice among dentists to order the administration of oral medications and to direct an assistant to hand the tablets to the patient.

Complainant's position represents an overly-rigid interpretation of the standard of care and Business and Professions Code section 4170, subdivision (a)(1). So long as respondent ordered the medications for legitimate dental purposes and adequately supervised the dispensing process, no violation of either the standard of care or the code section may be found. In this case, complainant proved violations in the dispensing of a sedative in two ways: Patient L.M. was dispensed two Valium tablets by respondent's receptionist, not in respondent's presence and without his supervision. (See Finding 28(E).) Further, Helena Pham admitted in her testimony that she routinely (more than 20 times) handed pills to patients in her capacity as receptionist.

(D) Records of the dispensing of medications must be maintained to comply with the standard of care. Complainant's witness testified that respondent's logs (Exhibits Q and 27, pages 481 – 483; see Finding 27(C) and footnote 8) did not comply with the requirements. According to Dr. Hancz, the record must include the dentist's DEA number and license number, the address as well as name of the patient, and an indication as to whether the prescription is original or a refill. The record must be sent to the California

Department of Justice on a weekly or monthly basis, depending on the schedule of drug dispensed. The record does not require the signature of the patient, but does require the signature of the prescriber.

Dr. Nahigian testified that respondent's log (Exhibit Q) was within the standard of care.

Respondent's records of controlled substances and dangerous drugs dispensed were inadequate. Certainly, for the period prior to October 2004, when no log whatsoever was maintained, respondent violated the standard of care and regulatory and statutory requirements.

(E) One who dispenses medications directly to a patient in the office must offer the patient the option of a written prescription that the patient may have filled at a pharmacy of his or her choice. It is below the standard of care to dispatch a staff member to fill a prescription and then to dispense the drug without having offered the option to the patient. Further, the prescriber/dispenser must supply the patient with a written disclosure that he or she has been given a choice of obtaining a written prescription or having the medication dispensed directly from the prescriber.

Dr. Nahigian did not offer an opinion on these issues. The evidence clearly established that respondent did not offer a written disclosure to patients, nor did he verbally offer to give a written prescription instead of directly dispensing the medications. Patient L.M., in particular, affirmatively testified she was not offered a written prescription, even after having inquired about one, and she testified that she was uncomfortable with being dispensed medication when she was not sure of the source of the drug.

(F) Dr. Hancz was not critical of the practice of keeping prescription medication for a patient, so long as the patient consented and all record-keeping rules that applied to drugs obtained from manufacturers were observed. Likewise, it was within the standard of care for a staff member of the dentist to pick up a patient's prescription (and pay for it) with patient consent.

Aiding and Abetting an Unlicensed Person (Tenth Cause for Discipline)

59. Kimberly Moore was employed at respondent's office for nine years as "the head nurse and assistant office manager." Despite her use of the term "nurse," Ms. Moore was neither a registered nurse nor a licensed vocational nurse. Rather, she was a "dental assistant" who received a diploma in "Dental Assisting" from Bryman College in 1992. Ms. Moore has never been licensed or registered in any capacity by the board. Ms. Moore completed a 12-hour Bryman course in coronal polishing and testified that she thought her "Certificate of Completion" of the course represented her "license" to do coronal polishing for respondent's patients.

60. Kimberly Moore performed coronal polishing on patient K.H. (see Finding 28(D)) and bleaching (whitening) on patient L.M. (Finding 28(E)). Ms. Moore testified that she regularly performed whitening procedures on patients as respondent's assistant, but she acknowledged performing coronal polishing on her own.

61. Respondent testified he thought Ms. Moore was licensed to do coronal polishing, but admitted a violation of the rules regarding those activities. With regard to whitening, respondent confirmed that Ms. Moore's merely assisted him, primarily by holding and directing a special lamp that is used in the procedure. Respondent also testified that Ms. Moore routinely provided suctioning and obtained x-rays.

62. Respondent aided and abetted the unlicensed practice of dentistry in that he allowed Kimberly Moore to do coronal polishing. The charge that respondent aided and abetted her practice of teeth whitening was not sustained.

Grounds Alleged for Revoking Respondent's Probation

63. By virtue of his conduct and his conviction for possession and use of methamphetamine, and his conduct and conviction for the dumping of waste on February 20, 2004, respondent violated condition 3 of his probation to the board that required that he obey all federal, state and local laws.

64. By virtue of condition 4 of his probation, respondent was obligated to file quarterly reports with the board "on forms provided by the board." Complainant did not contend that respondent failed to file the reports, but rather, that he failed to provide certain information required by the form.

(A) Respondent filed a quarterly report on April 21, 2004. At page 6 of the form, respondent was required to affirm or deny the following statement:

> From the date of the Decision of the Board of Dental Examiners of the State of California, placing me on probation to and including the date of this declaration, I **HAVE** been arrested or charged with a violation, or been convicted of any violation of any Federal or State statute, or County or City ordinance. (If answer is affirmative, use extra page for explanation.)

(Emphasis in original.) Respondent circled the answer, "No." He signed the form, under penalty of perjury, on April 15, 2004. The response was untrue.

(B) Respondent filed his next quarterly report on July 13, 2004. Respondent, under penalty of perjury, again answered "no" to the identical question recited above, denying he had been arrested for any crime. The response was untrue. Respondent did not

personally advise the board of his February 20, 2004 arrest until he submitted his next quarterly report, on October 15, 2004.[21]

(C) In five quarterly reports submitted between April 2, 2001, and April 13, 2002, respondent failed to disclose that he had been charged on March 31, 2001, or that he had been convicted on November 5, 2001, of reckless operation of a watercraft.[22]

(D) In respondent's quarterly reports of April 21 and July 13, 2004, he represented, under penalty of perjury, that he had abstained from the use of drugs. The response was untrue.

65. Condition 7 of respondent's probationary order required respondent to "inform the board in writing within fifteen (15) days of any change of place of practice or place of residence."

(A) At all times relevant, respondent's residence address of record with the board was 6234 Napoli Court, Long Beach. Respondent listed that address on all of his quarterly reports.

(B) When respondent was cited for the reckless operation of a watercraft on March 31, 2001, he gave the citing officer a driver's license that represented his address was 17024 S. Clark Avenue, Bellflower, his father's office address. Respondent neither lived nor maintained an office at that address. At the hearing, respondent testified that after he got out of dental school, he lived with his father in Long Beach and used the Bellflower address as his mailing address. However inadequate that explanation may be, the evidence did not establish that respondent changed his office or home address to the Bellflower location to trigger a reporting obligation under condition 7.

(C) When respondent was arrested on February 20, 2004, he gave the arresting officer his residence address as 607 Utica Avenue, Apartment 3, Huntington Beach. He provided that same address on a lease agreement form signed by him on July 31, 2004. Respondent testified that he lived at the Utica Avenue address on a part-time basis with his girlfriend for two or three years between 2001 and 2004. Respondent testified he also lived at 305 Utica in Irvine. Respondent had an obligation under condition 7 to report the additional addresses to the board and failed to do so.

66. Condition 12 of respondent's probationary order required him to abstain from the "use and possession of controlled substances unless legally prescribed for medically or dentally diagnosed health reasons for a bona fide illness or medical/dental condition."

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[21] On July 28, 2004, respondent's counsel sent Mr. Nicas copies of the arrest report and related documents. But this information was nevertheless tardy, as the earlier quarterly reports filed on April 21 and July 13, 2004, which did not disclose the arrest.

[22] No violation of probation is found for failing to report an "arrest" on March 31, 2001, as the evidence shows respondent was issued a citation only on that occasion.

(A) Respondent violated condition 12 when he tested positive for methamphetamine following his arrest on February 20, 2004.

(B) Respondent tested positive for Alprazolam and for Oxazepam following a random drug test conducted on October 15, 2005. Respondent provided a prescription for the Alprazolam from Dr. Comer, but he did not produce one for the Oxazepam.

(C) Respondent tested positive for various drugs drom April 2001, to April 2003. (See Finding 54.) Of those drugs, respondent produced, or the records otherwise indicated, prescriptions for anabolic steroids, Xanax, Diazepam and Alprazolam. The substance Oxazepam was detected in the test of November 8, 2001. Therefore, even assuming the prescriptions for the other substances were valid, respondent violated condition 12 by testing positive for Oxazepam. Given the conclusions reached in Finding 52, respondent also violated condition 12 resulting by using other drugs, including Diazepam and anabolic steroids.

(D) Respondent possessed a large supply of controlled substances that was found at his home on March 1, 2005. While some of the tablets were located in bottles for which a prescription had been written, many were in manufacturer's bottles and respondent provided no explanation for their presence in his home. The clear inference is that the Alprazolam (Xanax) pills were for his own use and he did not intend that they be used by his patients. Additionally, Cyciobnezapine pills were found in his home in 2005 that were supposedly prescribed by Dr. Dinh, although neither Dr. Dinh's list of drugs prescribed nor his testimony included that substance.

Evidence Offered in Mitigation of the Charges

67. Respondent practiced dentistry and oral surgery for more than 10 years without any discipline based upon patient complaints of negligent treatment. Respondent has not been sued for malpractice. None of the 17 patients profiled in this case complained of poor treatment or adverse reactions to the drugs prescribed or administered by respondent. Some of those patients and many other patients submitted letters on respondent's behalf, attesting to the effectiveness of respondent's work and the professional and gentle manner in which they were treated by respondent and his staff.

68. On December 7, 2004, respondent, aware of the board's ongoing investigation of him, arranged with the Fountain Valley laboratory of Central Drug System, Inc., to collect urine samples and arrange testing for the presence of drugs in his system.[23] Respondent has gone to Central Drug System at least weekly and provided samples of his urine. Until March 10, 2005, respondent tested negative 21 times in a 5-panel screen for marijuana, cocaine, amphetamines, opiates and PCP. Starting on March 10, 2005, the lab added barbiturates and benzodiazepines to the analyses. Between March 10, 2005, and May 16, 2007, respondent

[23] Central Drug System, Inc., collected the samples, which were tested by another laboratory, LabCorp.

tested negative for all seven categories of substances 170 times. He tested positive for benzodiazepines 33 times in the same period. No testing for anabolic steroids was done.

Steven S. Herbets, the current Chief Medical Review Officer for Central Drug System, Inc., testified that the collection of respondent's urine samples was carefully controlled. Respondent was required to empty his pockets and used a special room in which to supply the sample. The records from five of the tests between May and September 2007 indicated that the collection process was actually observed by a Central Drug System, Inc., employee.

69. Lawrence R. Moss, M.D., a psychiatrist, testified on respondent's behalf. Dr. Moss, who has been in private practice since 1985, currently spends two-thirds of his time providing forensic services. He was retained by respondent to evaluate respondent's mental health. In furtherance of that goal, Dr. Moss interviewed respondent in June and August of 2007, and administered the Minnesota Multiphasic Personality Inventory (MMPI), a widely used and accepted test of mental health. Dr. Moss testified that respondent seemed open and not defensive and that he is not a danger to himself, the public in general or to his patients in particular, for any psychiatric reason. Dr. Moss found no indications of anger, rage or aggressiveness. Dr. Moss was not asked to assume that respondent had, in fact, abused multiple controlled substances.

Complainant's Claim for Costs

70. Complainant submitted a certification of the costs of investigation and enforcement of the matter pursuant to Business and Professions Code section 125.3. The claim for investigative services costs in the amount of $31,546.20 was supported only by the following summary: "November 24, 2004 to September 2, 2007; 355.25 hours @ 88.80 per hour." The certification was signed by the Executive Officer of the board. No indication was given that the "actual costs," required by Business and Professions Code section 125.3, were not available for presentation as evidence of the costs. However, during the testimony of Mr. Nicas, documentation in the form of the investigative activity log was also offered and received into evidence. It included handwritten entries of the investigators' actual time for work performed during the timeframe referenced. Mr. Nicas testified to the accuracy of the hours that were worked and claimed. The log was prima facie evidence of the reasonableness of the costs pursuant to section 125.3, subdivision (c), and, given the complexity, breadth and scope of this investigation, the hours devoted to the case appear reasonable independent of that presumption. However, on cross-examination, respondent elicited that 10.0 hours were spent on clerical matters on April 11 and 12, 2006, by Mr. Nicas. As the hourly rate charged for investigative work already included an element of overhead, including clerical overhead, it was unreasonable to also charge the full investigative hourly fee for times when Mr. Nicas had to perform clerical work. Therefore, the claim is reduced by 10 hours, or $888.00.

71. Evidence of the costs of enforcement was presented in the form of a "Certification of Prosecution Costs: Declaration of Shawn P. Cook." Mr. Cook declared that

he was personally familiar with the time recording and billing practices of the Department of Justice (DOJ), that he requested a billing summary for the case and was provided with a document known as a "Matter Time Activity by Professional Type." The document purported to list by date, attorney, type of task, number of hours and hourly rate, the work of the Office of the Attorney General on this case. The activity detail was attached as Exhibit A to Mr. Cook's declaration. The claim thus documented is in the amount of $36,557, at different hourly rates depending upon the time period and category of individual doing the work (i.e., whether attorney or paralegal). The amount claimed is based on 244 total hours at an average billing rate of $149.82.

72. Unlike the claim for investigative costs, concerning which investigator Nicas was available for cross-examination, respondent was not afforded the opportunity to question any individual time entry or to question the hourly rate that makes up the costs of prosecution. Respondent attempted to call Mr. Cook to testify, but Mr. Cook declined to serve as a witness based upon "office policy" that prohibits a deputy attorney general from testifying. Mr. Cook was advised by the Administrative Law Judge that he was not immune from testifying in appropriate circumstances simply by virtue of his status as trial counsel, and that having offered his own declaration as proof of relevant facts, he subjected himself to cross-examination. Mr. Cook was not persuaded to testify, although he was warned that his refusal to afford respondent his right to confront him as a witness on the question of costs would be taken into account in the determining the reasonableness of the costs claimed.

73. The DOJ summary of activities performed was extremely general in nature. Descriptions such as "investigation," "discovery," "analysis/strategy," "case management," and "trial preparation" were commonly used. No description of more than four words (e.g., "communication with other party") was provided. While a declaration is sufficient if it describes "general tasks performed,"[24] the declaration under consideration falls short of even that minimal requirement.

74. The judgment that the matter was complex and broad of scope is no less applicable to DOJ than to board investigators. However, it is also noted that the presentation of evidence at the hearing utilized investigator Nicas' original documents, numbered and in the form Mr. Nicas devised for presentation of the case to the DOJ. Mr. Nicas also appeared to have primary responsibility for retaining, communicating with and coordinating the services of all witnesses, including experts. Given the extremely vague nature of time entry descriptions and respondent's inability to question those entries in any way, fairness requires that the claimed costs of enforcement be reduced substantially. It is determined that the hours be reduced to 75. At the average rate indicated, the costs approved for prosecution of the matter are, therefore, $11,236.50.

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[24] California Code of Regulations, title 1, section 1042, allows costs to be presented in the form of a declaration that "shall describe the general tasks performed, the time spent on each task and the method of calculating the cost."

75. Total reasonable costs for the investigation and enforcement of this matter are $41,894.70.

LEGAL CONCLUSIONS

Respondent's Motion to Exclude Evidence

1. During the hearing, respondent moved to exclude much of the evidence gathered by investigators Nicas and Crabtree on the ground that the evidence was obtained in violation of respondent's rights of privacy, his right against unreasonable search and seizure, and his and his patients' rights under the Health Insurance Portability and Accountability Act ("HIPAA," 45 U.S.C. § 1320d, et seq.). Specifically, respondent objected to the receipt into evidence of the pharmacy records obtained without the benefit of a subpoena, warrant, the consent of respondent or his patients or notice to them of the impending requests for information. Respondent also objected to statements and information obtained from doctors and patients interviewed by the investigators, as their identities were gleaned from the purportedly illegally obtained pharmacy records and because they were likewise not served with subpoenas or warrants, and the patients were not given notice of the interviews of their doctors. Finally, respondent objected to the testimony of complainant's expert Larry Trapp because his opinions were founded upon the purportedly illegally obtained or tainted evidence.[25] The parties briefed the issue during the hearing. Ruling on the motion was reserved, to be included in this Proposed Decision. The parties agreed that the pharmacies, doctors and dentists contacted by the investigators in this matter were covered by HIPAA.

2. HIPAA, which became effective in 1996, required the Department of Health and Human Services (HHS) to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addressed the security and privacy of health data. HHS promulgated rules and standards in furtherance of the patient privacy objectives of HIPAA, which, as applicable here, are found at Code of Federal Regulations, title 45, section 164.512.[26] HIPAA prohibits covered entities from disclosing patient information unless one of several exceptions applies. Respondent argues that only 45 CFR section 164.512, subdivision (e) arguably applies: "A covered entity may disclose protected health information in the course of any judicial or administrative proceeding: (i) In response to an order of a court or administrative tribunal, provided that the covered entity discloses only the protected health information expressly authorized by such order; or (ii) In response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal," if certain other pre-conditions are met. Respondent relies on the lack of a court order or subpoena in his argument that no exception to HIPAA justifies the investigators' actions.

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[25] Respondent moved that the following exhibits, or portions thereof, be excluded: 1B, 13, 14, 15, 16, 16A, 17, 18, 19, 20, 21, 22, 23, 24, 26, 28, 35, 36, 38, 47, 50A, 71, and 85.

[26] Further references to the regulations shall be cited as 45 CFR.

3. Respondent ignored the exception provided in 45 CFR section 164.512, subdivision (d), which was relied upon by complainant in his brief. That subsection reads: "A covered entity may disclose protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight of: (i) The health care system." The board is a "health oversight agency." The investigation undertaken by Mr. Nicas clearly fell within this exception to the HIPAA prohibitions, and it permitted the involved pharmacies, doctors and dentists to provide the limited information relevant to the investigation of respondent.

4. Respondent next argued that the search and seizure conducted on March 1, 2005, while pursuant to a warrant, exceeded that warrant and was conducted so egregiously that the fruits of the search ought to be excluded. Although some authorities have declined to apply the exclusionary rule to administrative proceedings (see, e.g., *Gordon, J., Jr. v. Santa Ana Unified School District* (1984) 162 Cal.App. 3d 530), respondent correctly points out that the proper approach is to balance "the social consequences of applying the exclusionary rules and ... the effect thereof on the integrity of the judicial process." (*Emslie v. State Bar of California* (11 Cal.3d 210, 229.)

5. Respondent argued that several aspects of the March 1, 2005, search exceeded the authority conferred by the search warrant and represented conduct that, if the poisonous fruits of the search were admitted into evidence, would reflect badly on the "integrity of the judicial [administrative] process." Respondent relied on the testimony of his office staff personnel to the effect that the board and DEA agents entered the building with guns drawn, locked the doors, sequestered all persons present for interview and prohibited the entry, exit or use of phones by anyone. As a factual matter, the testimony that the board agents entered with guns drawn was rejected. The remaining conduct was described by peace officer witnesses as being routine, prudent peace officer tactics employed whenever a search warrant is served. Respondent offered no evidence to the contrary. On this record, it cannot be said that the conduct was so outrageous as to require that the evidence obtained should be excluded.

6. Lastly, it is noted that respondent was and is required as a condition of his criminal probation to submit to a search at the request of any peace officer. (See Finding 19.)

7. Respondent's motion to exclude evidence is denied.

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The Standard of Proof

The Accusation:

8. The standard of proof in this proceeding involving the accusation is "clear and convincing evidence." (*James v. Board of Dental Examiners* (1985) 172 Cal.App.3d 1096, 1105.)

9. Clear and convincing evidence must establish a high probability of the existence of the disputed fact, greater than proof by a preponderance of the evidence. It requires a finding of high probability. Evidence of a charge is clear and convincing so long as there is a high probability that the charge is true. (*People v. Mabini* (2001) 92 Cal.App.4th 654, 662.)

The Petition to Revoke Probation:

10. The "beyond a reasonable doubt" standard of proof does not apply to a criminal probation revocation hearing. The court need have only "reason to believe" that a probationer has violated his probation or committed a new offense. (*In re Coghlin* (1976) 16 Cal.3d 52.)

11. It is unlikely that the standard of proof required in a proceeding involving a petition to revoke the probation of a professional license is higher than the standard of proof required to establish a violation of probation in a criminal matter. Therefore, the standard of proof in a petition to revoke probation is determined to be a "preponderance of the evidence."

Legal Conclusions Regarding the Individual Causes for Discipline

The First Cause for Discipline

12. Cause exists to discipline respondent Scott William Sandarg pursuant to Business and Professions Code sections 1670 and 1670.1, in that he was convicted of crimes substantially related to the qualifications, functions or duties of a dentist, based on Factual Findings 12 through 19, and 22.

The Second Cause for Discipline

13. Cause exists to discipline respondent Scott William Sandarg pursuant to Business and Professions Code sections 1670 and 1681, subdivision (c), in that he was convicted of crimes involving controlled substances or dangerous drugs, based on Factual Findings 12 through 19, and 22.

The Third Cause for Discipline

14. Cause exists to discipline respondent Scott William Sandarg pursuant to Business and Professions Code sections 1670 and 1685, for the commission of repeated negligent acts, based on Factual Findings 25 through 35. The charge of incompetence is not sustained.

The Fourth Cause for Discipline

15. Cause does not exist to discipline respondent Scott William Sandarg pursuant to Business and Professions Code sections 1670 and 1680, subdivision (p), for conduct in his practice that represents over-prescribing of drugs, based on Factual Findings 25 through 35.

The Fifth Cause for Discipline

16. Cause exists to discipline respondent Scott William Sandarg pursuant to Business and Professions Code sections 1670, 1681, subdivision (a), 4060, and in violation of Health and Safety Code section 11170, in that he illegally obtained and possessed controlled substances, based on Factual Findings 36 through 52.

The Sixth Cause for Discipline

17. Cause exists to discipline respondent Scott William Sandarg pursuant to Business and Professions Code sections 1670 and 1680, subdivisions (m) and (n), and in violation of Health and Safety Code section 11173, in that he illegally and by subterfuge and the concealment of material facts, obtained and possessed controlled substances, based on Factual Findings 36 through 52.

The Seventh Cause for Discipline

18. Cause exists to discipline respondent Scott William Sandarg pursuant to Business and Professions Code sections 1670 and 1681, subdivision (a), and in violation of Health and Safety Code section 11170, in that he administered controlled substances to himself, based on Factual Findings 53 through 57.

The Eighth Cause for Discipline

19. Cause exists to discipline respondent Scott William Sandarg pursuant to Business and Professions Code sections 1670 and 1681, subdivision (b), in that he used controlled substances in a dangerous manner, based on Factual Findings 53 through 57.

The Ninth Cause for Discipline

20. Cause exists to discipline respondent Scott William Sandarg pursuant to Business and Professions Code sections 1670 and 1680, subdivision (m), in that he failed to

follow correct prescription and dispensing procedures, based on Factual Findings 58(B), (D) and (E).

The Tenth Cause for Discipline

21. Cause exists to discipline respondent Scott William Sandarg pursuant to Business and Professions Code sections 1670 and 1680, subdivision (c), in that he aided and abetted an unlicensed person to perform acts requiring a license (Bus. & Prof. Code § 1765, subd. (b), coronal polishing), based on Factual Findings 59 through 62.

The Petition to Revoke Probation

22. Cause exists to grant complainant's Petition to Revoke Probation pursuant to condition 3 of the disciplinary order in case number AGS 1999-12, in that respondent Scott William Sandarg failed to obey all laws during the term of his probation, based on Factual Findings 12 through 24, and 63.

23. Cause exists to grant complainant's Petition to Revoke Probation pursuant to condition 4 of the disciplinary order in case number AGS 1999-12, in that respondent Scott William Sandarg failed to accurately and truthfully submit quarterly declarations setting forth whether there had been compliance with all the conditions of probation, based on Factual Findings 12 through 24, 53 through 57, and 64.

24. Cause exists to grant complainant's Petition to Revoke Probation pursuant to condition 7 of the disciplinary order in case number AGS 1999-12, in that respondent Scott William Sandarg failed to inform the board in writing of any change in his place of residence, based on Factual Findings 65(A) and (C).

25. Cause exists to grant complainant's Petition to Revoke Probation pursuant to condition 12 of the disciplinary order in case number AGS 1999-12, in that respondent Scott William Sandarg failed to abstain from the use and possession of controlled substances, based on Factual Findings 36 through 57, and 66.

Discussion re Appropriateness of an Order of Revocation

26. It is indeed tragic that a dentist of respondent's apparent skill must be deprived of his ability to practice his chosen profession. Many patients will be inconvenienced. But it is for their protection, and not to punish respondent, that the ultimate remedy of license revocation must be the inevitable outcome of this proceeding. Complainant and the board cannot delay action in the hope that respondent will rehabilitate himself under the guidance of the same, or additional probationary terms. Respondent knew what was expected of him. He chose not to comply with the probation or the law. He became a danger to himself. The absence of patient harm to date is merely fortuitous.

27. Respondent alone is responsible for the circumstances that have brought him to this place. Complainant, respondent and the board agreed to resolve a prior matter and subject respondent's dental certificate to probation seven and one-half years ago. Probation was designed to permit respondent to rehabilitate himself and to provide assurance to the board and the public that he would not engage in misconduct. Respondent violated the terms and conditions of probation repeatedly. While the violations stemming from his failure to advise the board of his part-time residence address and of his conviction for the negligent operation of a watercraft may be considered minor and would not have resulted in the reinstatement of the stayed order of revocation, there was nothing minor about respondent's arrest for the possession of methamphetamine, or the charge that he was under the drug's influence, in February of 2004. Respondent offered no explanation for his failure to disclose his arrest and conviction to his probation monitor or to the board. The conclusion is inescapable that respondent attempted to conceal the facts. He cannot be trusted.

28. The act of dishonesty that was respondent's failure to disclose the February 2004 arrest was but one of several dishonest acts or statements of respondent that dominate this record. Respondent was untruthful when interviewed by investigators and again, under oath in this hearing, when he explained the circumstances of February 20, 2004, as being the result of the vindictive wrath of an ex-girlfriend. How did Ms. Nance plant 310 milligrams of methamphetamine, taped between two of respondent's business cards, in respondent's wallet without respondent noticing? Respondent claimed he was not under the influence of methamphetamine, even though he was found to be under the influence by an experienced, credible police officer, even though he gave a confession to the police, even though he made clear, unambiguous admissions under penalty of perjury and with the advice of counsel in connection with his criminal case, and even though he pleaded guilty to possession and use of methamphetamine. Respondent specifically agreed that his plea was entered because of his guilt and for no other reason and attempted to derive benefit from the court's diversion program. He cannot now be heard to profess innocence and explain his plea as the product of a promise of dismissal if he successfully completed diversion, particularly in as much as respondent failed in his attempt at diversion and was found to be not credible and unsuitable for diversion by the sentencing judge.

29. Complainant argued that respondent's involvement in sports and martial arts explained his use of steroids. The theory proved to be speculative, as is any other theory as to the precise reasons for respondent's steroid use. But it matters not why respondent has sought to obtain by questionable means multiple anabolic steroids. What matters is that clear and convincing evidence demonstrated that respondent did not procure or use these substances following legitimate medical examinations, advice or prescriptions. He admitted he obtained a controlled substance (pain reliever) on-line, without a prescription. His notes established that he consulted numerous websites that advertised the means to obtain steroids. He actually obtained steroids through out-of-state doctors with questionable credentials whom he had never met. Respondent did not consult his primary care physician about the conditions he claims legitimize the steroid use; in fact, he initially misled Dr. Comer about his use of steroids. Based upon the testimony of Dr. Fung, and mere common sense, it

cannot be denied that respondent's extensive abuse of anabolic steroids is, or certainly will become, dangerous and injurious to his health.

30. The theory that respondent diverted the sedatives Valium and Xanax from patients to his own use was not proved,[27] but it was established that respondent unlawfully possessed and used those drugs. Again, respondent's motives are not as important as the ultimate findings of possession and use. But it is probable, based on the testimony of Dr. Fung, that the sedatives were used to counteract some of the negative side-effects of the steroids.

31. There were other methods respondent utilized to obtain drugs. Dr. King, despite his apparent memory difficulties, seemed certain he had prescribed drugs to respondent on only one, or very few occasions. Blue Cross records indicated 16 such prescriptions. Dr. Dinh, by reference to his chart on respondent, prescribed medications for respondent on six occasions. Blue Cross records indicate 20 prescriptions. Huge quantities of drugs were found in respondent's fanny pack and in his home. The claim that it is not illegal to combine one's own medications into a single container for the sake of convenience when, for example, traveling, fails to explain why 415 pills were found in respondent's fanny pack or why respondent was unable to recall all the types of pills in his possession when questioned at the time of his arrest.

32. A final example of respondent's lack of candor in this matter was his explanation for his possession of various kits and substances whose express purpose was to mask the detection of drugs in urine. To place blame on "a friend" (who did not come forward to accept that blame) for the presence of the kits in respondent's garage was the weakest explanation imaginable. Even if true, it spoke volumes about respondent's state of mind that while on probation to both the board and the Orange County Superior Court for drug-related offenses, he allowed the devices to be in his garage and that he accepted some of them as gifts from a friend.

33. Honesty is a trait reasonably required of licensees who are entrusted by the State of California to provide important services to its citizens. "All public servants are properly subject to discipline for acts of dishonesty. Public service provides no hiding place for the dishonest and those lacking integrity." (*Brewer v. Department of Motor Vehicles* (1979) 93 Cal.App.3d 358, 364.)

Respondent is disqualified from licensure as a combined result of his convictions for crimes substantially related to the qualifications, functions or duties of the

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[27] This is not to say that some tablets originally intended for patients were not ingested by respondent. Respondent's sloppy methods of maintaining and accounting for sedatives may have simply afforded him the opportunity to take drugs belonging to his patients even if that were not his intention at the time of prescription. It is recalled that investigators found a bottle of Diazepam intended for patient I.G. in respondent's office (despite the fact that all patient Valium was supposed to have been combined in one container) and that the bottle also contained some other, unidentified pill. And the availability of these substances directly from the manufacturer would have made it unnecessary for respondent to divert them from patient use.

licensed activity, his long term possession and abuse of controlled substances, his various violations of probation, and respondent's dishonesty and established inability to rehabilitate himself while on probation to the board and the Superior Court.

ORDER

1. Complainant having proved by clear and convincing evidence certain allegations of the Accusation constituting cause for discipline, as found and enumerated hereinabove, Dental Certificate No. 4506, issued to respondent Scott William Sandarg, is hereby revoked.

2. Complainant having proved by a preponderance of the evidence certain violations of probation found and enumerated hereinabove, respondent's probation in case no. AGS 1999-12 is revoked, and the stayed order of revocation is reinstated.

3. Respondent shall pay to the board, as and for the reasonable costs of investigation and enforcement of the matter, the sum of $41,894.70.

DATED: November 8, 2007

TIMOTHY S. THOMAS
Administrative Law Judge
Office of Administrative Hearings